DOCUMENT RESUME

ED 328 761 CE 056 965

TITLE New Frontiers in Literacy: Education and Mental Health of the Homeless. Southeast Florida Training Center for Adult Literacy Educators Conference Proceedings (Miami, Florida, May 5-6, 1990).

INSTITUTION Miami-Dade Community Coll., FL. Southeast Florida Training Center for Adult Literacy Educators.

PUB DATE May 90

NOTE 129p.

PUB TYPE Collected Works - Conference Proceedings (021)

EDRS PRICE MF01/PC06 Plus Postage.

DESCRIPTORS *Adult Basic Education; *Adult Literacy; Behavior Disorders; *Economically Disadvantaged; *Homeless People; *Housing Needs; Literacy Education; *Mental Disorders; Poverty; Self Destructive Behavior

IDENTIFIERS *Florida (Southeast)

ABSTRACT

This document is a transcript of a tape of a conference on homelessness and mental illness conducted by adult literacy educators in Florida. Persons whose remarks are transcribed include Blanca Polo, Director of the Southeast Florida Training Center for Adult Literacy Educators; David K. Fike, author of a study on homelessness in southern Florida; Evelina Bestman, Executive Director for the New Horizons Mental Health and Community Center; Willy Harris, homeless person; Bennie Moore, member of the New Horizons staff; Janet Humphries, program specialist for the adult homeless of the Department of Education; and Dr. Melcher and Dr. Gonzalez, mental health experts. Questions from audience participants and answers to them also are recorded. Topics discussed include who are the homeless, how can they be helped, the New Horizons program, literacy education, and mental illness and community mental health needs. (KC)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

CONFERENCE PROCEEDINGS

SOUTHEAST FLORIDA TRAINING CENTER FOR ADULT LITERACY EDUCATORS

"NEW FRONTIERS IN LITERACY: EDUCATION AND MENTAL HEALTH OF THE HOMELESS"

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

MAY 5 - 6, 1990

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

B Polo
B Moore

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

RADISSON MART PLAZA HOTEL
711 N.W. 72nd Avenue
Miami, Florida

BEST COPY AVAILABLE

MRS. BLANCA POLO, DIRECTOR

I guess we're going to start for the morning. Good morning and welcome to our first training session for the year. My name is Blanca Polo, and I direct the S.E. Florida Training Center for Adult Literacy Educators. The Center is funded by the State Florida Department of Education, and it is located at Miami-Dade Community College/North Campus in the Office of Public Affairs. The director of our office is Florida State Senator Carrie Meek; you must all know her, and given the diversity of the ethnic and social groups in our society, the center was established to provide training for teachers in literacy to help the people who are homeless, limited English proficient, the unemployed, and the educationally disadvantaged. Today's workshop will help you to understand the homeless mental health, their social, and their mental conditions so you can help them become more functional in our society. Today and tomorrow we'll have speakers who are experts in the fields of literacy, psychology, and homeless affairs, and we'll also have tonight our guest speaker, Ms. Janet Humphreys, from the State Department of Education who will be speaking to us about the State's perspectives in helping the homeless.

To start our session today, we are going to have our keynote speaker, a professor of social work at Barry University. He is also the author of several publications that deal with the homeless, work groups, and family affairs, and most important he

is the principal investigator for the 1989 study of the homeless population in South Florida. He has very valuable information to share with us, so let us welcome our keynote speaker Dr. David Fike.

DR. DAVID F. FIKE

Thanks Blanca. I'm pleased to be with you and to be with you specially because of your interest in the problem. It is a large and growing problem and needs the intentions of many people like yourself, so that each time that I have a chance to talk with interested, concerned people, I'm enthused about doing that. One thing I've learned in the past two and a half years in which I've devoted my career mostly to exploring the problems of homelessness and solutions to homelessness is that in South Florida the community is full of heroes in the effort of finding solutions to the homelessness problem. It is solution that is an era when the Federal Government is not going to come down like a guardian angel and solve our problems for us. They are not going to come to Miami; they are not going to go to Chicago; they are not going to go to Los Angeles to solve this problem. That isn't the way that it's handled in 1990. Large problems exist and they grow, and we're in an era when the local community has to solve it's problems. We are not in the 60's any more; but there are heroes of that local effort around and that gives all of us courage. They're the Jose Greers of the community who established, virtually

on his own initiative and without resources, the Camillus Health Concerns, one of the vital health efforts in homelessness in the country. They're Dr. Frank Jacobs who solved the growth of the problem and put together a plan to build a huge 250 bed Miami rescue mission. They're Captain Ron Busaro of the Broward County Salvation Army that just let that organization to be the centerpiece of the growth of service programs in that community. They're Dr. Evelina Bestman who you'll hear from later in your conference, who at New Horizons Community Mental Health Center recognized early that many of the mental health clients in her catchment lived down the street and under bridges not in houses and apartments like mental health clients usually live, and she went to them. She established programs that were appropriate for them while most of the other community mental health centers still ran programs that assumed that all their clients lived comfortably in a home or an apartment some place.

And you who are in business of Adult Literacy are appropriately numbered among the heroes also. You're a piece of the puzzle. You're a key to one of the several of the doors that must be unlocked. Thanks for your work and your presumed willingness to be trained to do more work and better work in this important area. We have quite a lot of time together this morning and I'm thankful for that, but because of that generosity of time I want to start by telling you a few of the things that I want for us to do together this morning in teaching and learning and also a couple of things I don't want to have happen for us this morning.

I want to give a brief report of findings of the South Florida Homelessness Studies to start with, which I've been a principal investigator concentrating specially on the findings that are relevant to literacy education. Secondly, having offered some authentic and correct information about homeless people, who may be your next literacy education students, I want to take us to several topics which are especially relevant to this work and to spend some concentrated time on those using some techniques of small-group problem solving to maximize learning in those areas. The things I'll try not to do are to give you information about homelessness or literacy education that you already know. I suppose that I may have some professional knowledge of homelessness, but I'm really an amateur as it relates to literacy education; you are the professionals in that area and I recognize that, so you need to tell me when I identify some of my assumptions about literacy education whether or not I'm on the right track. I'm open to that; I want to learn from you in that way. The second thing I want not to do is to bore you, so I also want you to let me know about that. I'm not a lecturer. I'm a teacher, and I expect you appreciate that, and we're all teachers in our ways and because of that one of the things that we understand is that a learner is only learning when she or he is alert so let's work together to have us all stay alert through the whole program of the morning.

With this introduction, I want to start with one of my assumptions about adult literacy education. My assumptions come

generally from 31 years of social work practice experience. The first 14 of which I worked with poor people with problems in agencies in a few communities of the United States and the last 17 of which have been in social work education, but even in social work education, I've not stayed in the ivory tower, but I've stayed in touch with agency work and with the work with poor people as nearly as I could.

Now, first assumption: we start with the images of literacy presented to us recently by Robert Dinaro and Jane Fonda in "Stanley and Iris." How many of us have seen that movie or know about it? Okay, let me tell you a bit about that image of homelessness. It is the story of a essentially a man and a woman, the man is an adult of 35 to 40 years of age who presents a stable, generally non-problematic life, working as a dishwasher, as a yard man, in a sense living in a solitary but satisfactory life in a small rooming home in spite of his inability to read or write. He was one of those several thousands, hundred thousands, probably, of people who managed to move through our public school system and finish 10th or 11 or perhaps even 12th grade through social promotions and just finished not being able to read or write. The rest of the image in "Stanley and Iris" is the image of the exciting growth of this man with the tutoring of a thoughtful woman of his own age, but that's a good real case. I hope you have some Stanleys in your literacy education experiences, but I expect Stanley as not really illuminating of lots of cases in literacy education because they'll commonly not be that problem free.

They'll be men or women carrying lots of other problems into their lives with them aside from being unable to read or write, not having mastered basic literacy skills. Sometimes the other problems are contributing causes. They cause things to go awry and so learning didn't happen. Sometimes they're consequences learning didn't happen and so problems developed later in their life, but nevertheless there will commonly be other problems. That probably is in an nut's shell what will be the core of the learning in this program, I suppose, in the next couple of days that you're here and learning together. So, this weekend it will be important for you, I think, to explore the Stanleys in the communities needing and seeking literacy education, and also the people who are not Stanley, people who can't read and write and need your help about that but have a burden of other social problems also. Let's go now to a report of some of the findings of the homelessness study that I think are relevant to you. After first reminding you or telling the story of the South Florida Homelessness Studies some people find the story of the South Florida Homelessness Studies more interesting than the findings of it. In the winter of 1987 and 1988 a wealthy 70 year-old businessman by the name of Victor Posner was convicted of tax evasion in the United States District Court in Miami. That businessman had given a plot of undevelopment land to Miami Christian College claiming for tax purposes that was worth $7 million when by best estimates it was worth about $3 million. The Federal Criminal code is tough with white color criminals now and the maximum sentence for that offense is 40 years

in prison, nothing more, nothing less than a claim of $7 million for a $3 million gifts brings a 40-year sentence in Federal prison or can now. In the winter of 1987 and 1988 also there existed an apparently large clearly visible problem of homelessness in Miami. The Federal Judge Eugene Spellman hearing the Posner case needed at least figuratively and expects sometimes literally to walk over the prone bodies of homeless people to attend the Posner trial and hear the testimony. The Federal court, and we think as many as 2,000 people share space in the center of the city of Miami. No one else thought those two things, Mr. Posner's conditions and homelessness in Miami went together, but Judge Spellman did. In his brilliant and creative mind they came together and he ordered in the Posner case. I find absolutely no benefit to sentencing you to a term of incarceration. It's a court's intent that you will submit a proposal for a comprehensive study of homelessness in South Florida. It is intended that the studies would propose solutions and that you personally would participate toward implementing those solutions with contributions of at least $3 million, and that sentence was carried out. We've been invited here today to talk about the results of that decision. The results of that decision are an integrated set of six studies proposed by me, authorized, and completed. The first study is an enumeration study and social survey of circumstances leading to homelessness in South Florida. Dr. Andrew Cherry of Barry University is the director of that study. The second study is a field study of life on the streets in South Florida. Dr. Bryan Page of the University

of Miami is director of that study. Study three was the study of mental illness and substance abuse among the homeless in South Florida. Dr. George Warhite of the University of Miami was the director of that study. Study four was a study of homeless families and children. Dr. Jeffrey Shillet of Florida Atlantic University was director of that study. Study five was the study of model programs addressing problems of homelessness in other communities in the United States. Dr. Elaine Nouring of Barry University was the director of that study. Study six was the study of economic and public policy causes of homelessness in the region. Dr. Mylan Deluwee of Florida International University was the author of that study. Let's go forward to some of the findings just a few of the hundreds of findings that are present in the whole set of studies. The past two years then I've spent most of my professional times studying homelessness in these communities through these studies, but in fact my role was at the start to recruit these six studies directors and set them off on their work and after that for me to be in touch with virtually all of the program personnel and the programs addressing homelessness in the region. I just spent my time in the road visiting people who were at work on the problem, including running community forums in each of the three counties a year ago in the Spring. Let me tell you just a couple of dozen things out of the studies then that are facts now that were not in evidence before. From Dr. Cherry's enumeration study we know that on a cold night last February we had a night when temporary red cross shelters where open when the

voucher's program had funds in them and more than 4,200 homeless people where in shelters or in motels or hotels or apartments on vouchers. That won't be repeated very often. We are usually not that generous. The 4,200 is probably about half of the homeless population in South Florida we expect. We expect that now we've exceeded the 8,500 that we counted last spring. In Dade County about 4,900 people were homeless that night; that's 2.7 per thousand. In Broward County about 2,100; that's 1.8 per thousand. In Palm Beach County about 1,500; that's 2 per thousand population. We further understand that we're approaching a time in which half of the homeless will be families, a quarter of the homeless children. Many of the homeless are working as much as they can and at wages as high as they can earn or they're disabled or on welfare benefits and they still can't afford a place to live at current prices. Sixty-three percent of the homeless people in our surveys have finished high school at least. They are not typically dropouts. About 15 percent have education beyond high school. Many of these, however, seem to be victims of social promotions not really having the education experiences implied by the grades completed statistic. Some have recently come to Florida, about 30 or 35 percent we think have recently come to Florida, but as in the education experience statistic as in the work experience most are local people who are homeless in their local communities; that 30 percent figure which jumps to an extent in the winter that is from the winter counts so that probably represent a 30 percent elevation of our winter population over our summer population and might

represent some people coming to South Florida from colder places to have a more pleasant winter. It's different, for example, than Phoenix among the other warm weather places where in the winter 55-60 percent of the homeless are there from out of town, may be as a tourist place and as an attraction for homeless, Phoenix might be a greater attraction than Miami. From Dr. Warhite's study of substance abuse and mental illness among the homeless, it now seems that the proportion of these people that are suffering from severe mental illness may be as much as twice that as other urban communities; and further, it seems that the common assumption that it is schizophrenia that's more prevalent among homeless people may not be true here. Severe depression is probably more commonly the condition that keeps these people locked in homelessness among the mentally ill homeless than schizophrenia; and this is not circumstantial depression. It would not go away. This is not depression that would or will go away when and if these people are in a better economic condition. It's a lasting condition and needs treatment and it calls for treatment. Further from the Warhite study, we understand about substance abuse among the homeless that the balance between alcohol and drug abuse may be twice as high here on the side of drug abuse as in other communities. It is about 50/50 here, and in other communities it's about 2/1 in the side of alcoholism among homeless people. Among homeless adolescents, perhaps, as many as 60 percent or more are alcoholics or drug addicted people. The addiction has sometimes triggered the run away or the throw away, and sometimes it has emerged after the

departure from the family home encouraged by life on the streets. At this point, I want to depart and say a thing or two about these facts, namely, what we know about the homeless adults and what we know about the homeless adolescents as they relate to who will be your literacy education students in the future. At present, they are as we indicated four out ten substance abusers; four out of ten are probably mentally ill; probably two out ten are free from those disorders. The next generation of homeless people coming on, the people who are 16, 17, 18, and have started life on the streets also are much more commonly substance abusers. When this generation of homeless people come into the adult homeless population, those substance abuse numbers will continue to go up. It will serve yourself well to become quite familiar with the implications of substance abuse including the recovery process from substance abuse. Saying that your people would be mired in the depth of substance abuse, but very commonly probably they're likely to be people who are recovering from substance abuse. So it's very important for you to know the implication of substance abuse. From Dr. Page's field study of life on the streets, we know the details of life of homeless individuals, adolescents, and families. They are different in those three groups. It's important for you to work on those distinctions. Probably, you saw homeless individuals the last time you visited Downtown Miami. Probably, you did not see homeless families or adolescents, and there's a good change you won't. That's not an accident. Homeless families and homeless adolescents live a lifestyle in which they perceive at least they

need to stay in hiding. Homeless families do so to protect their children from the troubles of open life on the streets and also to stay in hiding from children service authorities that they believe may take their children if they are found to be living in that condition, and they may well be right about that assumption. So they act as though they are on regular business, and they deny their condition to most people. Adolescents are staying in hiding because they are trying to avoid detection as run aways, and to stay away from adults who pray on the them for the drug and prostitution trades or if they have gone to selling drugs or there bodies for incomes, they would pretend to have residences to avoid hassle. From the field study, we also now know that there are many places where sizeable number of people live outside of residences all over these counties, not just a few. We mapped 50 sites or communities or homeless people in the three county areas. About half of them are in the cities of Miami, Ft. Lauderdale, and West Palm Beach, and about half of them are outside of the city. The truth of the matter is that there are homeless people all over all of these counties. Last month the United States Census Bureau used our maps to guide the processes of street counting that was done by the Census Bureau for the first time in the United States history. The homeless do not have good self-awareness of their condition or their needs. Let me walk through that with you. If asked, went to homeless people on South Beach or Downtown Miami or any of the sites and had conversations with them, many of them will tell you, if asked, they enjoyed the freedom of their lives on the

streets, that life isn't awful here; and hearing that it's easy to be lead to think that homelessness is voluntary. Lots of people these days are lead to believe that homelessness is voluntary. Sadly, all of our recent precedence have come to believe that also and kind of white washed the problem with that supposition, but let's go forward from that. If your next question is: what would you need to get off the street? What they almost always tell you is: "all I need is a job or all I need is some money." Okay, let's put those facts together with other things we know. Four out of ten are alcoholic or drug addicted. Four out of ten are mentally ill. No more, probably, than two out of ten free from disorders. So, that makes the supposition, "all I need is a job or all you need to do to get me off the streets is give me some money" is nonsense. That's nonsense! They need a program; they need rehabilitation; they need a transitional process and those are in very thin supply here. So, the truth of the matter is that wanting to being on the streets, being on the streets voluntarily is not literally true for more than a handful of homeless people. "The life is okay here" really means: "I like it better here than the alternatives I know about, and the alternatives I know about usually includes a period of hospitalization," and so the message really is "I really don't want to go to the hospital. I'm not ready to go to the hospital, yet." From Dr. Shillet's study of homeless families and children, we now know that there are a few families with histories of stability of life and employment, but not very many. There are some cases in which job loss or some

other life-changing circumstance has tumbled a previously stabled family into homelessness, but clearly most of South Florida's homeless families are multi-problem families. Typically, they are mother-headed families with about three children. One common configuration is one or two school-age children and one or two pre-school children. Another common configuration is two or more school-age children and teenager, 15 or 16, who is already out of the home. Probably in this place family homelessness and adolescent homelessness come together. Probably there are several hundred cases of families homeless and adult adolescent homeless from the same family. There is putting out process in these very poor chaotic families. Often the homeless family is on AFDC, facing the consequences of levels of payment of only 65 percent of basic needs. Often it is a homeless two-parent family with an unemployed father. That family would qualify for AFDC for the employed benefits in most states, but they are not qualified here. Florida does not participate in that program. This family, typically, has made two or three moves already in the past year before they move to the shelter. With each move they have had problems getting their children started in school. The family shelter is likely to be one clean room of about 12 x 15 feet with a private bathroom. The people who reside in the family shelters often say the shelter is "the best place we've ever lived in." These kids and these families have great resilience. Most say their lives aren't dramatically out of control, but there is a large ominous 30-40 percent minority of the kids who are having

problems. Let me list some of the problems. They are greatly discouraged. They are very angry at their parents and other adults. They blame themselves, partly, for their family's homelessness. They tell stories like I hear my family, I hear my mom or my dad say to me if it weren't for you we'd be living in the suburb some place. These moms and dads, some of them aren't doing a good job of shouldering the responsibilities for this and are placing them upon the six and seven and eight year old kids. Thirty to forty percent of the kids don't like themselves very much and the strange hunting one even at age 7 or 8 or 9, 30 to 40 percent of these kids say they think a lot about giving up. They think a lot about not really trying to making it in this life, just kind of floating through. There is long troublesome life time ahead for a kid who has given up at age 7 or 8 or 9. From Dr. Nuring's search for model programs in other communities it is known that many communities are doing many things that we are not doing here now. Basic components of the homelessness program in other communities, not in place here include, screening and tracking system for substance abuse and mental illness among the homeless. A regular system to try to get that information on the whole homeless population in the community. Second, is day centers, which are multi-purpose centers, multi-service centers including a secure comfortable place to spend the day. You may or may not know that the shelter system, good or bad as it is, with all its characteristics essentially is a night-time system. It's the place where you can stay at night and you need to go back out on the

streets, generally in the day. This is not true of the family shelters, but it is true of the large volume individual adult center. Broward County is in the process of establishing a day center and we'll have in operation by fall. It will be first of the three South Florida counties to do that. Employment and training programs that can bring people out of homelessness in other communities usually have living arrangements built in to them or living allowances or social services built in to them. There are lots of employment and training programs available. You know this very well. I'm probably venturing into the area that you know very well, but they don't have living allowances in them, and they don't have any way for somebody to live while they are in three months of training to learn to repair T.V.s or other that could give them a good trade and living is a problem as well as to work. Other cities and counties found programs with millions of dollars. Also there are a great many partnerships on public, private, non-profit, and private for profit organizations for funding and operating homelessness programs in other communities. There is some of that here, but not nearly as much as it's needed. From Dr. DeLuwee study of contributions of economic and public policy factors in the rise of homelessness here, it is now known just how wide is the gap between minimum wage earnings and cost of living here. Minimum wage earnings provide $538 per month income. Whereas a family with two children must pay an average of $410 per month rent for a two-bedroom apartment in the lowest rental areas in these urban areas, plus other living expenses. That family then

is needing to spend about 75 percent of its income on housing, and that doesn't work. We know together that doesn't work. Families cannot afford to pay more than 30 to 40 percent of their income for housing. They need the rest to pay for other expenses, and that isn't the end of it. If you need to get into such an apartment, you need to pay an average of $775 of deposits and advance rent payments to do so. It may as well be a $1 million to this minimum wage family; $775 just is a fantasy. However, minimum wage can't even be assumed in this community. There exists here a very large underground economy of cash payments of less than minimum wages without benefits fueled partly in the presence of undocumented immigrants without formal permission to work here. Employers who need low skill labor can buy it this community for cash payments of $2 an hour or $2.50 an hour. You surely can't afford to support a family on that. We also know from Dr. DeLuwee's study that the stock of low income housing is very low here, and the public investment is called for, but low cost of housing supply can also be increased in some cases without massive increases in government funds through other initiative such as inclusionary zoning. Many communities are saying in inclusionary zoning plans that you are a developer, you want to develop property, you want to build houses or apartments, you want build middle income or upper income property. Okay, you can do that if you will also build some low income property and increase our supply of our low income property. You need to build both to build the one. We aren't yet forceful enough in our zoning processes to say that. They are also other

communities altering their building codes in such matters as density, as incentives to building low income properties. They are saying further to developers so you need to build a lot of apartments to get your money back from your investment. We will allow you to build closer to the lot line. We would allow you to build smaller units than we otherwise would permit or alter zoning processes in a few different ways if you are willing to help us to build up the supply of low income housing in this community. Let me at this point pause; it's kind of at a point between sets of ideas that I want to talk with you and invite you to pose the questions that you have. I have presented to you a few dozen ideas from the study. I have presented you with some ideas about homelessness. Let's have some questions and dialogue together to check out things that you heard and you wonder about, question about things you didn't hear and you wonder about. What here raises points of discussions in your minds? Yes, Sir

Just one, basically, you have covered a lot, but what I really want to know is there anything really being done to .....
if someone is continually, consistently put down for every emphasis they make to overcome these different obstacles .....
is there anything really being done to educate this people that need to be brought out of the syndrome that they are in to the effects and the causes of the.

Yeah, I think so. We'll go on to some of the efforts that are specifically in that form to help individuals. There are some things that are happening structurally for example. Also, it is

a catch 22 if you are working as hard as you can and you still can't earn enough to do more than live on the street. That's a problem. The basic form of that in these communities is working in the labor pool. Working in the labor pool the basic source of work is the labor pool. You earn $20 a day and you need 4 for food and five for this or that and even if you can save your money, which isn't likely. There's a good chance somebody will steal it from you before the end of the week, on the streets, but even if you could put all your money aside in saving you wouldn't be earning enough to get an apartment. You wouldn't be earning enough So that's a basic dilemma, and there are some structural things out of that dilemma it is a policy of the Bob Braward employment and training agency for example that it will not deal with minimum wage jobs. There are employers coming to the agency all the time saying we want to participate in your on-the-job-training program because you guarantee some stability in your on-the-job-training program because you guarantee some stability in your employees. They are connected with you and you are helping them and they're better employees that if I pick people generally of the streets. It is the policy of that agency, the employment agency in Broward County for example to say: okay we will deal with you if you pay at least $5 an hour. We know what the minimum wage law says, but we also know that people can't become independent on less than $5 an hour. So we will work with you; we will support you; we will enter into a cooperative agreement with you if you pay $5 an hour because we know then that we are doing something of value for our client. If

we participate with you in $3.35 an hour we're participating in a facade of something that can really help and bring that man forward. Yes Sir.

Dr. Fike what is Victor Posner's involvement with the Homelessness Study at this point. This is a three-part question. In other words, when he put up the $3 million dollars, did that end his involvement? What is he doing now to be connected with the project, and when you commissioned to be the principal investigator of this study, who did you report to? I am trying to get a sense of structure of this thing. Secondly, where can we get a copy of this six part study?

Interest bearing account for a long time and so its probably back up to $3 million dollars again and the foundation is being set up. There's a process of a foundation being set up to make annual grants for the next few years out of that funds. Probably the center piece of what this community service will be is that he would participate in studying the grant applications and study the worthiness of them along with the board of trustees of that foundation so that when the 16 or 20 or 37 application for grant funds come in this fall and they are evaluated. Victor Posner will participate in studying the programs that have requested grants to make some observations about their worthiness. I trust and believe he would not do it on its own. He would not be a good judge. In fact, he doesn't understand homelessness well enough to be a good judge of proposals. If somebody would just pass a pad we have copies of the study Victor is paying for that too. If you are

interesting in the summary of a finding, put your name and address on a pad. Dagmar, somebody, can somebody pass a pad and I will send one to you. About the process of data gathering, the first four of the studies were original data gathered from subjects 3 or 400, 6, 7, or 8 homeless people randomly selected in the counties were interviewed in structured processes. They were original data studies. The last to the model program study was a national inquiry of what's happening in Arizona, what's happening in Philadelphia and so forth, lots of mail materials and lots of phone calls. The economics study was a study of public documents out of the F.I.U. study of public policy that have contributed to the problem and an analysis of employment and unemployment in the community and analysis of the institutionalization processes and analysis of housing experiences and so forth from published documents in these communities. Sr.

Were you able to detect a trend of homelessness increasing in the future and if so what are the causes, the main causes that would have a strong influence on homelessness in the United States.

Well, first can I predicted a trend. We will be able to. I am finished with my Posner money studies, but I am continuing voluntarily to do counting in these three counties over the next couple of years. I promised that as a voluntary effort, so we will have good trend information in a couple of years. The cause of why the trend is continuing is that the factors, the forces that started happening about a decade ago haven't been evaded. We haven't started building low-income housing in any of our

communities. We haven't gotten a handle in the unemployment situation. We haven't reformed welfare programs. We still have tight restrictions on welfare program. It's still hard to get workman's compensation. All of the factors that started ticking off about a decade ago are in place. What we have done is started programs and good programs to draw people out of homelessness one by one. I could name the good programs that this is happening. We're successful in some cases, but as soon as we draw one person out of homelessness through a good effort, two more fall in because the forces that tumbled them in are still there.

About 35 percent of the homeless men are veterans. About half of those are Viet Nam Vets and about half of them are veterans from earlier wars so that it's a bit higher than it is in the population. Though it's arguable whether it's sufficiently higher to say that it's been a cause in lots of cases. Probably its been a cause in some cases, but I don't think we have evidence that it's a cause in lots of cases.

Education in the family shelters is a subject of a national debate, and we're trying to sort that out. It's probably mainly tough to sort out because it's a tough problem. That is you would like them to go to their local school and be in a regular school program so you are tempted to say, let's do it in the neighborhood school of the shelter. Other communities are saying, no we want them to be in their home school; we want them to stay in their Liberty City school or their Heatherwood high school, where they would go back to when they finish their time in the shelter and

they want to stay in their community, so they bus them back to their home school. A third thing is to set up schooling systems in the shelter themselves. Yes, shelters are attempting to do that and it's a naughty, tough problem, and it hasn't been sorted out yet, but it's the best plan. Mostly the center of the problem is quick registration in this family shelter. In this family shelter study said to you these families on the average have eventually ended up in a shelter already moved three of four times that year and change their residence. Each time they've moved it's taken three or four weeks to get their kids reenrolled in school and that's just unexcusable. That's just ruins a year; that just ruins a school experience if you have three months of the year out in moving that's just despicable. Sir.

I have a question concerning the homeless adolescent. The first question is what is the voluntary process occurring with homeless teenagers getting help with substance abuse. What's being done in terms of that? Second question is in terms of homeless adolescent females. What is being done to prevent pregnancies or are they using birth control?

Some things are being done generally. There are done in generic programs starting with the birth control process. Those services are available in basic public health locations but nothing especially designed for the several hundred women in that condition on Ft. Lauderdale Beach for example. They have no special facility for that. If they make it to the health department for that service, they get it. If they don't, they don't. There aren't

special programs. There is a specialized program for teenage substance abuse in this community, the Gilbert Center, residential program. It is an advanced idea and it does not have space. It has about 30 beds and uses them well, and that it's not enough for a community of this size. That is the only specialized program for teen substance abuse in the South Florida area, we started at least. Generally, it is a very important missing piece and the substance abuse enterprises have not yet gone effectively enough into the work of adolescence substance abuse.

I was just wondering are there any case studies or follow up studies of people who have gotten out of homelessness and how they changed their attitude and how they got out of their homelessness to help inspire people who are presently homeless that there are some solutions.

How have they have come about it? Are there any programs or testimonials that are available to help encourage people that feel they are in a very hopeless situation?

I am sure that there are some successful cases around, and I don't know of a book or monograph that have pull them together in just that form. It is a good idea. Somebody should do that. Let me just say something about coming out of homelessness, the process of coming out of homelessness since you talked about it. There are a few forms of that, and it's important in understanding the whole problem to understand the several forms of coming out of homelessness. To start, people come in and out of it everyday. It's a fast changing population. The population of homeless people

that's on the street today will not be the same population of homeless people that's on the street tomorrow. It is a myth to suppose that it is the same batch of people that's been out there for three years. That's not case. People come in and out of it all the time. That's the truth. Sometimes they come out of it because they've been successful in a program. Miami Rescue Mission, Successful Graduates of Miami Rescue Mission 6-months program. They went to the new Junior League Women's Transitional Shelters that's recently open. They stay six months and got things together and came out of it and they were successful in one of the programs. That's the case often. Unfortunately, it is not usually the way out. Usually the way out is finding another informal temporary solution someway. Getting your mother to agree to take you back into her house, finding your sister-in-law to agree to let you stay in a spare room again, finding a boyfriend who will take you in for a week or two. That's the informal system. That's how people usually come out of homelessness. That's how people usually get undefined as homelessness. Sadly, they'll be back. The third one, there are some easy cases. One of the things that's floating around that you will hear from time to time there was a T.V. special about six weeks or so ago. The tag line to the except we are all a check or two from homelessness. We've all heard that by now. None of us have a big fund of savings so that if something would happen we are all just a paycheck away from homelessness. Well, there is an element of truth to that but only an element of truth. We have said to you that many of the people who are

literally homeless in these communities have many problems aside from not having enough money to pay rent, so that's the truth. The other part of the truth then is for the people who tumble into homelessness having had a long history of good work, just lost the job, just had an accident and were injured and so they can't work for a time. In accidental circumstances they're easy cases. The truth of the matter is for those people all you need is to get them another job. All you need is to put then up for a while until they get another job, and then they'll right forward and work steadily again. I have some cases that I'll be presenting to you in a little while. I isolate some of these dynamics also. Madam -- Question by a participant.

Answer -- In absence of basic skills of living. One of the things I'm going to get to as we go forward is the content of programs of life skills training. The homeless programs around the country are adopted as a central model of orientation to their program in the absence of certain basic life skills or absence of preparedness for certain basic life skills. We'll answer that better when we get into that part. Well, it's partly literacy, but some other things also. You can tell me whether all of the life skills that I'll talking with you about fit into literacy of whether they don't. That's something we'll have a dialogue about. Let me go forward. Thanks for the enthusiasm of your questions and for directing me into the specific things you're specially interested in. I want to kind of enrich the flavor of the statistics that I've been throwing at you, tell you about three

real cases that are in the case load of an agency in Broward County that works with homeless people, a case management agency. They are not ideal cases, they are not great success stories necessarily, they are three real typical cases that illustrate the people that are the homeless that may be your students. Mrs. A. is a 35 year old single parent mother of 7. Two of her children are over 18. She started having children young and are independent. Five are still with her. In her early life. Even though she was having babies in her early life, she completed 11 years of schooling but did not learn to read and write in that process. She spent her early adulthood in relationships and brief marriages working as a domestic in hotels when you could. Now, with 5 children including infants she must depend on AFDC, but her life is not stable enough for that bureaucratic system, and she keeps getting cut off even from the meager AFDC allowance that she is eligible for. She moves without notifying AFDC people. She knows she has to have birth certificates for all involved people before she gets reinstated. She keeps losing birth certificates. So it is difficult when she resurfaces and tries to come back into the system to get back into the system. She spent the last couple of years moving around among the shelters in Broward County and living with friends or in subsided apartment in the system. Her life is in chaos and at present there is no plan in motion to change that. Her whereabouts presently are unknown. She is in one the in between times. Whereabouts are unknown to the case workers that could help her, but she will surface again in another month

or so and come back into the system at some place. Mrs. C. is a 21 year old single parent with three children and she is five months pregnant her fourth child. She also completed the eleventh grade and is probably functionally literate. In fact, she has had quite a good life for this youthfulness and for this many pregnancies. Between ages 17 and now, she has been in and out of relationships with the fathers of her soon four children, and she has also shown a diligent work history. She has been independent until recently. She worked at a fast food restaurant for two years, working all she could and practically supporting herself and her kids, and worked at a security job for six months. With work and food stamps she had a stabled low income life until her fourth pregnancy created a crisis. She moved, at that time, into the nome of her mother and stepfather, but could stay only a brief time because there was conflict there. There was to much conflict for her to have a good life. She went to AFDC at that point. She got emergency money from H.R.S., and she has stabilized her life again with grants from those sources. In spite of a dreadful missing piece of the puzzle. Broward County has no publically subsidize three or four bedroom apartments available now. They will not place a family of this size in a two bedroom apartment that violates their density rule, and there are zero larger apartments. The housing system in Broward County cannot help her find an apartment because she has too many children. So she found one on her own, and she found one she could afford, and she is there stably now. She was diligent enough to solve this problem as she

was diligent enough in getting and staying at work and she will have her baby and she will go back to work and she will be independent again; that's her nature.

Mr. D. an individual adult man is a single 41 year old man. He's lived for a time in Illinois and in Tampa, Florida, but not as a transient, but seeming genuinely interested in finding the best environment for living so he would go to a place and stay for a few years and then move to another place and stay for a few years. He hasn't moved for the season at all, that isn't the case with him. He is a high school graduate with some college courses and a reasonably good work history in clerical work. He is prepared himself to work in offices. He can type; he can file; he can maintain records. He is a recovering alcoholic having had in-patient treatment the last time in 1984 and has generally maintain sobriety since then. He's had two periods of two full years of uninterrupted employment in clerical work. Recently he's gone through a bad time. Probably returning to drinking. He agreed to be in an employment program and to have subsided housing in a boarding home during the end of the job training experience, but wondered away from the home where he was place and from the program and his whereabouts are not know to the agency now. Partly, I want you to just experience who these people are and to add that to the facts we have been playing with, but I do want also to direct your attention to a few of their special features. Mr. D. is down right now, but he will probably come back. It's very important that do not lose his clerical social skills to do office work. It's very

important that he do not lose the capability of working in an employment situation like office work. If he drops to the point of needing to do manual labor, then he may be dune for. He may not be able to maintain himself in the absent of being able to work side by side with executives and other secretaries and wear clean clothes to work and have the social expectations of going to work in an office. If he drops away from that, that's a problem. If you and your literacy program, if you in the community college can help that man or help that woman to keep from dropping out skill labor to unskilled labor you'll be performing a very important service.

Mrs. C., a 21 year old woman, if you don't remember the initials is a great reservoir of energy of the human spirit including a strong, clear drive to be independent. She is receiving public support now during her fourth pregnancy, but she'll soon be independent again. She will insist on that. That's another among are the people who are the homeless.

Mrs. A. life and family are out of control and the failure of the schools to make her literate during her 11 years of trying is a contributor to that. I hope a powerful enough remedy for constructive intervention even with the Mrs. A. is found. It would take a pretty complicated powerful woman in that tough case. I want to pose any other questions or adding cases, dimensions to the other facts we have been dealing with. Sr. Question by participant.

Answer -- Yes, that's right. Just to add a couple of ideas to that, to support it mostly. In relation to relationships these people have had back in their family and friendship in contrast to the relationships they described in their community they create under the I-95 underpass, they do have relationships on the street, and they aren't wonderful, but they do support each other, and they aren't great. They don't trust each other very much for some good reasons, but the thing that is not included in them that often people have been worried about is the sense of responsibility, the sense of being responsible for the family I left or for my mother who's ill really could use a visit from me or something that is a part of the thing that's on the minds of some of this people, and they're worried about the responsibility that I'll be to go back into the other living circumstances.

Question by participant -- I'll like to know if there's any materials available to help do an evaluation study to assess how we can help these individuals and any type of material that you recommend so that we can instead of just reading them that we would be able to assess their actual needs and how we can go about in implementing meeting those needs, any studies that you recommend or any fill-out forms that we could do to help us to evaluate.

Answer -- I'm going to deal with that as I did with the other questions. I think when we get into an analysis of life skills present; absence of life skills in a bit I think that's the best material that I can direct you to that would be helpful to you in that way. There are assessment systems that are built in presence

and absence of basic life skills, and there are structured systems of analyzing and understanding a subject from that perspective. Let me move forward then to what I promised a couple of times.

In homeless service programs around the country the kinds of programs that most providers are most enthused about for the people who need something more than just money or housing, those easy cases that we talked about, need something more to get restarted, is usually called life skills training. Now that means many thing to many people, but basically it involves efforts to find important deficits in homeless people in the fundamental behaviors that are evident in successful people and absent in unsuccessful people. We could explore the people that we know and kind of separate successful people from unsuccessful people and to help the homeless person acquire those behaviors or skills. The question about what are those skills for success isn't yet definitively answered but those who fairly frequently get put into these programs are problem solving, making and keeping friends, and forming social networks for mutual helping, getting work and keeping a job, handling your money, being functionally literally, aspiring to elevate yourself economically and in level of responsibility. Those are just some to give you a beginning flavor of what we're talking about. Whatever is on the list it's work that many homeless people will need to do to move toward independence. For the remainder of our time together this morning we'll be talking about the content of life skills training and I want my intentions about this to be clear. I am suggesting that you should formally do life skills

training, I expect some of you already do it, and that's good. I know that many of you teach or want to teach basic literacy. My prayer is that you continue doing that. It's very important. For you literacy teachers my aim and concentrating on the content of life skills content is that as you help your students finally to read, write, communicate, and do math in the context of the other positive things that will be happening in their lives if they are progressing toward independence. I'm going to go forward and show you two different lists of life skills training. The one list, the one that I am going to refer to as the tangibles, and the second I'm going to refer to as the intangibles. This first list is a composite list that I've compiled from reports of providers of homelessness service around the country. I have followed up the six studies with the study of an additional study for free of a homeless service providers around the country about what they are doing to try to help homeless people and what they find to be the need of homeless people in their shelters or in their day programs so this is a composite picture of what 65 or 70 providers around the country have told to me. I don't need to read them to you. They are about getting and keeping jobs. They are about budgeting your money. They are about taking care of your children. They are about taking care of your apartment. They are about being neighbor and being like your neighbors. They are using training and education for growth and development. They are about making and keeping friends and about helping each others, and I'm keeping these safe separate because they are special cases in the case of

substance abuse, controlling it and the case of mental illness using appropriate treatment in it. Now, obviously, the things on this list are much easier to say than to do. The start of it strikes us as an, of course, or so what, but recognizing let's talk about what it's here and what it means and go back to some of the questions that we had about this. What it means, I think, and you can tell me your impressions of what other things it means. It identifies the field in which you need to operate. It identifies the field in which you operate in understanding these people. It identifies the things that they need to work on. It is a comprehensive list. For one person, he may be doing just fine with the going to work part and may be doing just fine with keeping the work part and being a good worker. He may be doing awfully with this one. If you are a literacy teacher who can't get your mind passed, well did you get a job yet? Are you still working? How many days did you work last week? Why did you take off on Friday? I got a call from your boss saying you took a three-hour lunch and you were only supposed to take a one-hour lunch hour. Don't be a one trick pony. Don't understand your person just in the context of his part in the workplace. This is a comprehensive list. The second thing it does is it identifies the areas in which you can be functioning. The get a job is not the end it's the beginning of analyzing that problem. How do you do it? What is the right one? How do you solve that problem for yourself? Let me take questions that I put off earlier about this. You were saying, so what is the area of the problem that people have? Are there some

generic basic things that we are to attend to. People around the country are using a set of ideas as a guide to things we are to attend to. Does it help? In what ways might it help?

There is a variation there that's important and let me talk about them. The second part of your question, I think, isn't necessarily true. I think that any of them could go to the Rescue Mission or another rehabilitation program. In the case of alcoholics is signing their own time, and that time may come seven years after they've been on the streets. It's not too late in that instance. Coming back to the two groups phenomenon. In a way there is the line between isn't as clear as it might seem, and has to do with how they've been on the streets. One of the other facts that's in our study that has surprised some people is that at any given time among the homeless adults street people 30-40 percent have just arrive there and have been there for one or two or three months. Now, that's a very important population because other people have studied that and know that length of time on the street is factor and how difficult it is to get off. One of the things that would be desirable to do is somebody start up a program of reaching out to people that have been out on the streets and do something special to the people that have been there only 30 or 40 days and pass the people that have been there for seven years. Not that we are not concerned about them, but in all cases it's sensible to go to people with whom you have a better chance of success. Now, when I say that line isn't quite that easy to draw, many of those people that have just arrived may have arrived with

very difficult problems. They may running away from the law in Illinois or whatever. That's not to say they haven't had the right to have problems, but it is a fact that many have just arrived and they haven't gotten connected with the street system where that is their main identification. They haven't gotten tide up with that gang of 12 or 15 guys that live together under the overpass so that has become sourceful system. They're just easier to deal with in a few words.

Dade County is one of the communities in the United States in which blacks make up the majority of homeless people. That isn't the case in all communities. That's the case in two or three other communities. As it relates to Hispanic homeless, we probably have more Hispanic homeless, but it is still relatively small proportion of the population. One of the things that's around to get into this is the kind of a time bomb that may be hidden in the homelessness problem, and this is one of them as it relates to Hispanic homelessness. If it weren't for the long tradition of Hispanic and Haitian families taking in their own people, we'd be in awful shape. We'd be in deep trouble. One of the things that's floating around you probably read in the homelessness literature is people, I say, naively saying we should start counting people who double and tripled up in homes as homeless. Well, that's a nice idea, but the fact of the matter is we often don't follow that tradition much. We feud with our families a lot and often in truth can't afford to take a family in.

Let me go to the other set of ideas that are here in life skills training. This is a guide that's a version of the content of the scope of the whole picture of basic functions in life in which these clients need to try to find success, and in the missing pieces of finding success here can identify the things that people are to attempt to. Let me now go forward to another set of life skills. This comes from a specific program of life skills training from a couple of social workers at the University of Washington Wayne Gilchrist and Steve Shenkee who have created and done training with populations like this. In another orientation to life skills training. In this case all built around the tasks and behaviors of problem solving. What separates the people who go through life solving their problems and going on with their lives from people who just muck around in their problems, have the same ones today that they had five years ago are still bussing around with them rather than getting on, defining the problem, looking for solutions to the problem, finding the best solution, putting it in place, and then moving on with their lives. What's separates the one group of people from the others? What are the skills of doing that? is the set of ideas that Gilchrist and Shenkee identify and talk about. People separate themselves on being able to identify their problems, to name their problems. What's your problem? What's keeping you from being successful? People deny their problems. People don't recognize their problems. People think is one thing when every reasonable person as an outside observer would think of another thing, so forth. People make errors in not

recognizing the consequences of their problems. They keep going through things wrong, doing it the wrong way, doing it partly or incompletely or inadequately and don't recognize what's happening to them as a result of that. They don't like what's happening as a result of that, but they don't connect it to what's triggering it or causing it to happen. People have difficulty because they can't control the stress in their lives. They just go through life without attending the stress they are creating for themselves, and they can't deal with their negative feelings of their lives. People cannot go through the problem solving process. People cannot make and implement some decisions, can't make decisions. They go around and around about and they sleep on it for a while, put it aside for a while, and when they go back to it, they just go round and round about for a time. Being in a bad marriage for years and years and years and years, and talking to everybody about being in a bad marriage. Finally, on the list the importance of affirmation of positive behaviors with self-praise. Does anybody has any specific, clarifying questions with this? I want to go forward and finish with this with another set of ideas that tag on to this and kind of flash out or give content to this set of fairly abstract ideas. The set of ideas that are build around principles of cognitive behavioral psychology. The form of psychology that suggests and argues that many people are dysfunctional because they are stuck with ideas in their heads they have had for a long time that on the surface makes sense to them that guides their lives, but they keep guiding their lives to dysfunctional behaviors,

rather guiding their lives to functional behaviors. Let me tell you a few of them that I think apply to the poor people that I've known in my life and the people that will be your literacy students. First one is this cognition. I put it as a "don't." It's the one some people are stuck with. I put it in the form of don't entertain yourself because you have problems. I have been feeling really bad, so I want to go out to a movie that would make me laugh. I am feeling really down so I want to go out and get drunk. That's entertaining yourself because you have problems. They one I would replace it with that would be more functional is entertain yourself, reward yourself for having solve the problem. You want to give yourself a movie. Give yourself a movie after you have worked hard and solved the problem and put it to rest. You have putting off visiting your brother. You have been working on cleaning up the house, cleaning up the yard, working on that old car, getting it running again, getting it out the yard, so forth. Do it, and then reward yourself. Use entertainment as a reward for solving your problem rather than to make yourself forget your problem. Second one I have here is don't be preoccupied with the unfairness of society. What I would replace that with is something like: understand society is full of unfairness; it's all around us; it happens to most people and most people don't get what they deserve. That's something that is just true of humanity, not just true of your. Don't be preoccupied wondering why bad things happen to you. Anybody heard that one? Why do things like this always happen to me? I'd replace that with: understand bad things happen

all the time, and they happen to everybody. Sometimes they happen for no reason at all. Figuring out the reason why they happen doesn't do much. Lots of times they just happen for no reason, and sometimes they happen because you brought it on to yourself. The last one that I put on this list is: don't fantasize about the time in which everything in your life is going to be wonderful. Generally speaking, life isn't wonderful. Generally, speaking for most human beings life isn't wonderful. What life is like really is a life in which you have done some important work on major problems and feel some satisfaction about that, some of your problems are solved. Not all of your problems are solved and even in the best time, there will some problems in our life, and one of them that you can surely predict is boredom. One of the problems that in everybody's life that's part of regular life is boredom. Just not very happy about what's happening now. You can look forward to that place and be satisfy when you are in that place, you are in a better place than you are stuck with the idea of looking for that utopia. Thank you for your willingness to work in this effort. Thank you for your willingness to come together with us today. I wish you good wishes and good learning over the next few days. I have appreciated the opportunity to be with you. Thanks for the invitation.

BLANCA R. POLO

Thank you David for all your helpful information, especially for the first date list that you provided to us because that helped us to help others and also not to make us fall into that trap. I was thinking, since we have all being very communicative today, why don't we go down the row and introduce each other, so we can become more acquainted with each other, and after that we can go on to the break and then we will go to the luncheon. Any volunteers.

I am Steve Appelbaum with the Project Restart with the Dade County Public Schools of Adult Education. I am Shirley Robbins and work with Dagmar in the VISTA project. I'm Tom Nehrsted; I'm a teacher. I am Dagmar Pelzer with the Dade County Schools. I am Janet Humphreys with the Department of Education. I am Brian Olson. John Blake with New Hope for the Homeless. I am Oscar Rodriguez and I work with New Hope for the Homeless in South Beach. I am Eugenia Rolle; I work the New Horizons Homeless Program. I am Gene Pugh, Florida International University and Employee Training and Development. Kaekay Gray; I'm a board member but I am also a teacher. Emma Duffie; I am with the Southeast Florida Literacy Center at Miami-Dade, North Campus. I am George Bryce, Peace Corp volunteer; right now I'm a semi-retired teacher. Rick Fonseca, Director of Center for Professional Development at Miami-Dade Community College, North Campus.

Great! It's a varied group, and I think that we can all get together and do a great job to help this people out there. I am really thankful to you all.

BLANCA R. POLO

I need your attention, please. We have a very nice lady here with us today, Dr. Evelina Bestman. She's the Executive Director for the New Horizons Mental Health and Community Center, and she is going to talk to us about her center, the services that they provide, and we'll also have some very nice guests here today with us. These are homeless people who are residents for New Horizons Community Center, and we have very interesting information to share with you today. Welcome Dr. Bestman.

DR. EVELINA BESTMAN

Thank very much. It really is a pleasure for me to be here with you this afternoon. As I was looking in my schedule for today, and we have the Friendship Games, which is an annual affairs for the Mental House Community here is Dade County is on the park and this morning I was there, didn't participate in the director's races, but I knew I had to be here at noon so I changed in the car. You always accomplish your goals, and my goal was to be here, and so I did it. I am excited too about the area of homelessness because in growing up in life, my parents trained us with the philosophy of "but for the grace of God, there goes I." We know what we are today, but we surely don't know what we shall be tomorrow, even with all the planning, so you have to really have your hearts go out to people who are in less fortunate positions because it certainly can come to you whether you realize it or not.

We have some members of our program here who I am going to ask, at some point, to really share with you information about their lives because they did not expect to be homeless either as they saw people who where out on the street. In regards to the homeless mentally ill, we are a community mental health center, and we specialize specifically in services to the homeless mentally ill. There are certain characteristics of this population, and I know Dr. Capp will be getting more into looking at some of the personality dynamic of a particular population, but as for our particular project, New Horizons was awarded a small community support grant in the amount approximately of $120,000 to serve and to develop a profile of the homeless mentally ill within the city of Miami. In terms of that project over three year process we documented and counted over 319 individuals. They were largely within the age of 19-40, and the second large category was within the age of 41-60. Seventy-two percent were males, 28 percent were females. The majority were black. The next number came up were white within the city of Miami, then the third group was Hispanic. Thirty-six percent of the clients reported a past psychiatric hospitalization. Forty-five percent reported a history of psychiatric treatment. Sixteen percent of them were what we call duly diagnosed. In this case this is mental illness and substance abuse. When you get into some other fields, particularly in education, it could be mentally ill oddment to the retarded, but the dully diagnosed that we referred to in terms of our analysis dealt with those that had a mental illness diagnosis as well as

were substance abusers. The major mental illness diagnosed category was schizophrenia paranoid type and many of them are veterans. We are finding out as we deal with the population. Many of them are single overall, the majority 63 percent were single. We looked at the fact what kind of services can we provide as a demonstration project and we then are providing services now for the past four years, specifically directed to the homeless mentally ill. We have always provided services to homeless people, but I always say we get fads within the funding community and homelessness was the fad and now everybody says you have money to do homeless services even though you may have been doing the service before they weren't recognized. Now as we address children you'll see funding coming in for children and less funding for the homeless, so somehow we don't see that we can meet our needs, but at any rate, we have the initiative where money is coming specifically for the homeless population. We looked at the fact that the homeless mentally ill have a lifestyle consisting of a chosen set of culturally appropriate behaviors evolved through a learned developmental process for both the homelessness and the mental illness. We see homelessness as a culture within itself. We are at the center developing a model program looking at what were the needs for the homeless mentally ill. One was that we looked at the fact that many of the them are long term mentally ill. This came about as a result of what is called a deinstitutionalization movement. The deinstitutionalization refers here to the fact historically the mentally ill were housed and many

people call it warehoused in psychiatric hospitals, such as South Florida State Hospital. Then we came to the point where the public was saying we don't funds to really continue keeping this monstrosity of facilities which really are not providing treatment, but are just warehouses. So they end up being residential establishments. The other thing is that with the invent of psychiatric psychotropic medication which are enabled many of those who were displaying what is called psychotic symptoms, which you say you know this person is crazy that were able to take medication and those symptoms became less and thus once they were put out of the hospital they were able to manage to live within the community. If they weren't aware of crisis because they didn't take medication or some particular stress, then you establish what is called crisis stabilization units where the individuals that come in for up to 14 days are medicated undergo therapy. They calm down, get stabilized back out in the community so they can continue to function. Given this, they what is indicated in literature is that the number of people who were let out of hospitals have not been able to receive care out in the community nor adequate housing because there is not very much affordable housing and thus many of them are out on the street not by choice. If they are getting benefits and they are in boarding home, if they don't "fit in" they are put out. There are not many of their families also enable to care for them in terms of dealing with the mental illness and so you have people who really reside on the streets because the services are not available for them. We met with various providers

within the community, drug providers, Dade County, people from the school system to find out what services you think would be needed for this particular population. We were told that you cannot have a service unless you have houses. That's one of the primary components. We set up what we have residential facilities and I'll get to that. A component, though, in terms of initially was that they needed to be outreach. An outreach means that you have staff members who go out into the community to find the homeless people wherever they are. Let them know that the services are available, build trust in the relationship, and it takes time to build trust in a relationship in any sort of therapeutic endeavor. You think of the fact that when people are very mistrustful because they have been rejected enlarge by society, they don't trust, why are you here. The other part is that the mentally have been warehoused, as I said, and hospitalized in the past against their will, so they are always suspicious that when you come out to say that you are offering help that you are going to take me and put me in an institution again, and so I don't want to be discovered, don't do me any favors. We built up an outreach team as our initial step which is case finding, going out finding where they are, to the shelters, on the street, under the bridges, wherever they can vacant abandoned buildings to let people know that we are there. We have a mobile van which went out usually there were soup, cookies, doughnuts, coffee, and staff, including psychiatrists who went out where the people were to let them know that if they need assistance they would be seen. The clients really responded to

this. When the Nicaraguan situation occurred, there was a cause within the community, a real uprising because people were responding to the Nicaraguans who were supposedly homeless and yet they were called Americans who were on the streets and nobody seemed to care, so upon the opening of the stadium, our team went out in the mobile van, provided services, screening and assessment of the individuals who were on both sides of stadium because it was divided, the English speaking on one side and Nicaraguans or Hispanics on the other side. We provided services on both sides in terms from an outreach perspective. We also provided housing through Federal Emergency Funds. We were able to have hotels, motels, boarding homes that would accept clients once we identify they're from the stadium at least house them for a month. At the same time, we were going with getting their benefits for them. The second element of service that we have is what we call mental health treatment. Let me back up to outreach because one aspect of our outreach was going into the jails. Whether you are aware of it or not many of the mentally ill and substance abusers who typically don't stay in shelters, a house in jails, which actually is against the law because they are supposed to be treated, but again since the community does not support treatment rather than have people on the streets and harm themselves or others. Many times the police would take them to jail. Under the Bay correct law even though you are harm to yourself or others the police can what they call Bay correct you. This is involuntary commitment to a psychiatric facility. Many times they hesitate to do that

because we can only hold you for 72 hours against your will. At 72 hours you are back out on the streets so they see it as revolving door. They prefer, and many of the people on the streets prefer as they say going into the jail so they can get three hot meals and a cot, and then they are out on the streets again and it becomes a system. So we have workers who went as part of our outreach team into the jails to do case finding to let them know that we have residential services so they did not have to use the jail as a place to sleep and to get meals because in many of the shelters you get a meal for a certain number of days and not always have free meals and on Sundays, some of them don't provide meals at all so you are dealing with people who do need to have food so that wherever they can get it whatever system is available will be utilized. That's one of the things that we did in terms of trying to intervene with the police in terms of the jail cycle. We have what is called mental health treatment, and this is where individuals are evaluated by psychologists, by psychiatrists, by social workers and use they are use to experiencing emotional difficulties. Based on that assessment and screening it is determined what treatment will be provided or often have the treatment particularly for homeless mentally ill if you do have the medication regime. Our psychologist, however, is very forceful what makes the program different from what happens with the regular mental health client. The rules to have the rehabilitated services for what is called adequate treatment is that of a person that's seen as chronic mentally ill, meaning that they have a psychiatric

disability. Then they are expected to have contact with the psychiatrist at least once a month. With our homeless mentally ill the psychiatrist requires that the contact is once a week or usually a minimum of twice a month. This is because when someone is under medication you really do have to monitor the individuals so that he does not let the time lapse go in terms or working with the population. We also have social workers who also provide therapy, counseling with them as individual as well as group. We provide intervention with the family members. We have drug and alcohol services. We do refer now to detox units, but we do have drug counselors in-house, and we have a day treatment program where many of our clients, in fact, we have a teacher through Dagmar's program who works very effectively with our clients in providing for vocational education, adult literacy skills. Also they are looking at how they can relate better within the community. There are some peers support groups in regards to this. The other service component that we focus on has to do with primary health services because we do believe in the holistic approach and when you work with homeless individuals you will see that they are multiple problems, multiple problems because living on the streets you don't have proper nutrition; you don't have the proper support services; you don't get proper health care; you are exposed to all kinds of diseases. Physical primary care services is very important. You are aware of some of those service sites such as Camillus House, which focuses specifically on medical services to the homeless population. Family health center we use. We also use

49

Dade County Public Health in regards to providing some of the services, and Jackson Memorial Hospital. We work with getting them screened, getting the proper medical care, and providing for whatever medication they might need. Dental care is also very important, so we try to get all of this in many of the needs of the client. We also feel that training services are important which we provide at New Horizons. We go out; we do lectures; we consult with individuals who want to know about the homeless mentally ill and how to approach them. It could be from a learning perspective. It could be at a job site. It could be just knowing what to do with the family members, so that we participate a lot in terms of providing training and consultation in working effectively with the population. We have residential care and I guess that's the most exciting part for many of the clients, and what I have been told, for example, there was a client who informed us on a Thursday after he had a job and informed our coordinator that he did not need New Horizons anymore. He had access to the bus; he had a job; he could make it on his own. That Tuesday there was a commotion outside of my office and this young man there saying that he was not going anywhere until I saw him. He did not want to see anybody else, so I did. I brought in the office and asked what I could do to help and he said that he had left the program; he had gone to Ft. Lauderdale; he was working part time there and was working on another job, but they thought he had pink eye and they fired him and he went to the homeless program in Ft. Lauderdale and they told that he would have to wait a month on the waiting list before they

can provide services to him, and he said that he had come back because our facility was the only one where the clients could stay until they had their act together and those are the words that he used, that we do not say that you have to leave until such time as you have moved to point that you are ready to go out and live independently and we assist you to do that. If you choose to leave, then that's your decision, and we don't lock anybody in. We do have a facility a crisis stabilization unit that does that when that's necessary, but that's a psychiatric determination and we can only do that, as I said, for 72 hours if the person is threatening suicide or threatening to kill someone else and we are aware of it. Then we have to have them in for an evaluation and screening. We have presently three different locations. One is in Overtown community and is an apartment building. One is in the Windwood area. It's mixed co-ed in the Overtown area. The one in Windwood is for males, and there is one in the Brownsville area, which is in a rooming house and that is also co-ed. We have a facility that has been renovated, which we are hoping would be opening within the next 30 days. It is very nicely designed, newly renovated and is to serve as an emergency intake, 24-hour facility for the homeless, members of the community, the police, or even you as educators. I think that something is happening here. You may not be sure. You are not the experts, but you might say, here is a place where you can go to be evaluated. You can call up. I need consultation. Which direction do I go? That's our newest venture in regards to making ourselves available, specifically as it

relates to the mentally ill or substance abusers population. I know we needed time for interaction. You know, when you are on the receiving end you are a better advocate for what happens to you. As far as I know, none of them expected to speak today. They were asked to be here, but just sitting next to me I have been hearing nice things in terms of the stories about their lives. I want to let any of the members of the project to say something; come and share with the group.

First of all, I am not mentally ill and just homeless, alright. I am here for one reason, get myself together. Once I do that, establish that I am going to go back out there in the work force going to the top, and we'll not take a fall no more because a lady like this gave me a chance, Ms. Anderson, all of you. Thank you.

Hi everybody. I am not mentally ill either; I am homeless. You know, I came to New Horizons and it's done a lot for me. Today I can say I am trying to get my GED; I am trying to get my life together, and I learned that I am somebody, so I am worth doing for myself, and they are helping me get it together. When I go back out there I'll be part in the neighborhood or in society. Thank you.

We condemn ourselves here within our community. This is not specifically with New Horizons, and the newspapers tend to say that this community is not responding to the needs of the homeless population and this young man is from Washington D.C. area and was saying to me he is so surprised at the volume of facilities we have

here compared to the Washington D.C. area which is the nation's capital.

I have been down here a year and seven months. I have seen the homeless in D.C. They live on the streets. They have gutted out buildings for the males. They have hotels for women that have children, but I was really amazed seeing the programs and the missions and the food lines and the clothes and the places they can go to get help. The people that are homeless down here are blessed. They have a lot to thank God for. I was really amazed. This program really works. They don't do this in D.C. If you ain't got it, you ain't got it, and they carry you through a living hell just to get help. A lot of problems is that you have to wait. If you are on the streets, you are on the streets until they decide you can come in. This program here, New Horizons, is the first program where I was able to come to and say well you come here, and they started me. I found out what they have to offer in the program and the benefits, and there is a lot to get out of New Horizons, a lot of new doors to be opened and I'm planning on opening all of them for myself. Thank you.

How did you hear about New Horizons?

Well, I was at the Miami Rescue Mission and I was trying to get my disability, so I had to go down to New Horizons to see a psychiatrist and through seeing a psychiatrist I talked to a young lady that's not here. Her name is Paula. I talked to Diane. Diane asked me if I want it a place to live. I said no; I already

have a place to live plus I have been there at the Mission long enough to go from the first floor to D dorm. Then my next stop was the fourth floor. That was the end of the program. I heard about New Horizons and I what they had here, and what they had to offer, and I thought about it, and before I left 36th street that evening I went back to Diane and told her that I wanted to move, could I move today. She told me no, wait until tomorrow. So they picked me up the next morning about maybe 9:30 - 10 o'clock and I came in. When I got down 36th street I got to meet the counselors and the social workers and they explained what they could do and what I can get out of it, and like I said, I'm studying for my GED. I always wanted to, but I was scared that I wouldn't make. I didn't want to take the test. I was scared I was going to fail it, but this lady here, Ms. Anderson asked me if I wanted to go for my GED because I came to her one morning and told her I wanted to be a counselor or therapist, and she said well you don't have a high school education; you haven't graduated. In another words, to me, she was telling me: Hey, I couldn't do that, and you don't tell me what I can't do. When she told me I couldn't do it, I said I am going to do it, and I went to this gentleman sitting right here. I am very bad on names. Tom, and he told me: "yeah, I can help you with your GED," and that's where I am now; so I tell everybody, there are a lot of doors, a lot of benefits in New Horizons. Go for it!

My name is Willy Harris. I am a member of New Horizons, the homeless program. Within New Horizons we have people coming from

many different sector. All of us there are not directly mentally incompetent. All of us there are not drug addicts. There are just different forms in life of how people come to be homeless. The facilities that they have there for you is better than I have seen in many different places. The kind of help that you get there, didn't think existed in a homeless program. I tried to fight it out on my own when this incident came upon me that I was more or less placed out on the street. By knowing some people within the community, they suggested to me that go down to the people at the New Horizons program and see if I qualify to become a client there. So upon my visit there I was seen by psychiatrists which was determined that I am not extremely mentally ill, but I do have paranoid seeing, depressionary problems for things that have driven me to be homeless, but as to this time now with the help of Ms. Anderson, the teacher Tom, and Ms. Jones, Javier, and all of the general people there, they are really helping me in a great deal, showed me different ways of attacking the problem, the medication that I take is helping me very well. It seems as though I would get another chance to go back in society and function as hopefully as good member of society and become tax payer again. You never think about when you work all of the time and you appear in the taxes to this different programs and you never think that it might be you that the same situation might be happening. At this time, I am in the receiving side, and I am kind of thankful by all the years that I have donated to the United Funds in different ways in order to help people. Any questions? Thank you.

Hi, my name is Annie. I am the pest of the program, but I am pleased to be here. I thank God for New Horizons. When I got here I didn't know the meaning of love or caring, but Ms. Anderson gave me opportunity to find myself again because I had totally lost me, but to find love to have a family again I thank everybody. Thank you.

I just want to share a poem with everybody, something I wrote. It was in the papers once. The title is "My Love".

My love we must choose to be
whoever drink the love I give
will never thirst, but indeed
the love I give will become a
spring of water ..... up to eternal love
I tell you open your eyes
and look at the love.
Who ever hears and sees my words
and believe my love is eternal
do not be amazed at this.
I see not to please myself but to please you
A laugh that burns to give light in life
and you choose for a time to enjoy my light in life.
All that the father give me will come to me
and whoever come to me I never drive away.

I cannot upstage that. Thank you. Any questions?

Can someone without legal immigration status take advantage of the services that you provide at the New Horizons?

Oh yes. In fact, we don't check for the status. This project is one of the many projects that we have. We have a specialized program for Cuban and Haitian refugee entrance and we don't deny services because of immigration status.

Contact Claude Charles because we also have a Haitian outreach center which is located up near 84th and N.E. 2nd Avenue, and Salvation Army, Legal Service, all of us are in there, and we have a staff member who is there who works specifically with the various families.

We currently house 20 individuals who are designated specifically as homeless. The facility that we are opening up is an additional 15 beds, and that's for short term to get people in, do an assessment. They even stay up for a month there while we help them get benefits and get them housed in other areas. It could be in one of those 20 beds that we have. In addition, we do have a total within the center. A total of about 80 beds for clients who need housing. So once they get stabilized, if they qualify for another part of the program, we can also have one of those beds and some of them have already done that. They have gone into some of our other apartment building that are not specifically for the homeless.

It could take lots of time and love and encouragement and I have to want this for me because I know what it was like to have.

57

I know what it was like not to have, and I don't like that. I like to have, so I'm glad I made that step, and I've made it.

One of our members came and met with me on last week because she has a history in journalism and was a public relations specialist prior to becoming homeless. She said I visited with lots of programs I want to work with you to get the message out because the homeless people know it. They know it, but in terms or the large community knowing about the services and that it is available and that it is different from others programs. We deal with the continuity and continual care. In fact, I have been trying to get off the ground a family support group specifically dealing with the homeless population.

What is your present situation as far as are you at capacity right now. Yes, that's a problem that we have at this point. We do a lot of our feeding at nighttime. We run into a lot of our problems at night time. A lot of programs their facilities aren't available if we don't get them registered by a certain time. All those facilities are closed off and unavailable, and we've come across twice with situations that need attention now. Mother and child got thrown out of the house now. We have no where to take them. I understand the situation there is no really set 24-hour programs because of our situations it really breaks our hearts because since we deal with a lot of the homeless at night time we have no place to take them. We can counsel them, but sometimes it takes more than our abilities and we are extremely limited. I also like for you to address the situation what can be done with the

community to get more attention because there is not enough facilities in the city of Miami to take care of the needs. If that statistic of 2,000 people in Downtown Miami alone is accurate we are looking at a situation that beyond our present means of taking care of them, and we need to build more facilities. What can we do as far as getting media attention to let the public know that there is a extreme need?

My comment in regards to your first part was about the fact that programs shut off if you don't get people in by a certain time. Ms. Anderson has taken some people home to even stay with her. We don't have a policy where you have to have someone over by 12 o'clock or else we are not able to serve them and that's why we have the 24-hour intake services, but again that is limited specifically to individuals who are showing some sign of mental illness in terms of that 24 hour intake. We are talking about the needs for additional facilities. We as citizens of a country where voting and political activism can make a difference. I know that the big corporations are in charge, but we see what happens in Russia. We see what happens in Rumania where people got together and they just said no. I think that we really have to act out on our convictions. We are all living. We go out to vote sometimes, we don't. I write a letter sometime. You might write a letter sometime, but the politicians get scared when they see people be consistent because they depend on the control of the lobbyists. The greatest lobbyist of the world when they it comes down to people power and those of us with social service do not bond

together and be consistent in regards to that and we can really make a difference. They know; when you deal with Dade County budget they tell you right up don't bother fire fighters don't bother the police because they going to be out there screaming. They are going to be packing, but you deal with social services, and every psychologist is sitting in their own private factors office. You don't see them down there in Dade County, in the auditorium. The social workers are in their little offices; they are not down there dealing. They will tell you. You talk with any commissioners. We know what occupations to not bother. I know that the homeless people just like they ..... Camillus House..... (end of tape).

.... and living on minimum wage. You cannot pay rent and everything else. If you are working on one job with minimum wage and usually that means that you have to end working two or three jobs in order to afford to rent some place. Usually public housing is not for single individuals unless you are disabled. It is designed for families. So you don't have assess to even that in terms of low income housing. That is a big problem. It is going to take really getting involved and action and developers. Developers when they want to get together and they see that they can get a dollar out of it then it becomes economically feasible for them, then they would do something about it. I think that those that are homeless can really... My brother is homeless and he doesn't really want his own apartment. These rooms and houses that I see. He just wants a room that he can lock a door, so it

is a matter of designing. He just wants to say that's my space and that's my privacy. I cannot afford a $400 a month rent plus all the utilities. What we find is that Dade County Welfare because he was getting assistance from them pay this guy $200 a month for a dump. I mean it is a dump. I know that some developer can come and do something decent because the government really is providing. Lots of them are getting rich out of the government's monies, but those who choose to qualify under the system.

Do you have a lobbyist for the homeless?

No we don't have. Not in the State of Florida. Mitch Schneider at the national level in D.C., but we don't have anybody in Florida who is really of that level who's doing anything, and we don't have a lobbyist, and maybe that's what some of us who are all interested in this can deal with in terms of funding for a lobbyist, using some of the funds to deal with having a lobbyist.

MR. BENNIE MOORE

Some of you might want to speak to the members during the break that's going to follow, but I think at this time we owe an applause to Dr. Bestman and the members of the staff.

Mr. Moore I keep hearing about Tom. Who is Tom? This is the teacher who is making the difference in their lives.

Evelina. You have so many programs. You probably have a hundred Tom's. At least you can identify this Tom. Tom is doing a good job, and he is one of the persons that we owe. I also like

to recognize the fact that I have know Ms. Bestman for a long time, too many years to even mention, but I would like to offer the resources and the technical assistance of the Institute of Citizenship Education at Miami Dade to help organize the lobby on the local level for the homeless. I'd like to address what Dagmar Pelzer said, and by the way, Dagmar coordinates the homeless program for Dade County Public Schools. We are in the process now of getting a telephone conference between Senator Carrie Meek, Roger Cuevas, Joe Mathos, myself, and maybe we will include you on Monday because there is a piece of legislature that I think is almost lost that would give the type of funding exercises where you would not have to charge these people for those classes that the homeless need. I think that on Monday Carrie is going carry it in the Senate side and then we have an advocate in the House side, so will be talking about that. I also like to recognize Dr. Willimerle Marshall who is in charge of Dade County Public Schools Special Programs for Students, and we are glad that you were able to join us at lunch because I am sure that you can add some more insight to the workshop as we go along. Finally, I would like to recognize the presence of the person who coordinated the homeless program for the State Department of Education, Ms. Janet Humphreys, who is our main speaker at dinner tonight. Janet will be able to tell you some thing about the State but mainly will be able to take some things back to Tallahassee that you would like to have the State Department to know. I hope everybody would stay put. We are

going to take a brief break, then we are going to reassemble in the next room where we are going to have Dr. Larry Capp. Thank you.

(end of tape)

63

Janet Humphreys

I started working with the Department of Education in January, so I am rather new with this job, my job title actually, is programs specialist for the adult homeless. The adult homeless, I was going to tell you, I just learned my job title, I have been with this job for four months. Adult homeless literacy training and basic skills assistance project. Actually it only took me two months to master this job title. I just had a little lapse since then but after that time they sent me out to visit our four projects that we established last year to go out and see what is happening with the homeless in the State, what is all the fuss about the homeless and take back a report to the 12th floor of that glass building in Tallahassee. Tell them what is going on. So tonight I would like to share a little bit of my research with you. A little bit about what has been going on throughout the the State with our Literacy Project and what the future looks like right now for our project. I was really glad to hear about this workshop on mental health. I actually know a little bit about mental health that mental illness, irrational thinking. I have a 13 year old at home and actually 13 year olds are not considered to be, you know their irrational thinking is'nt considered to be mental illness, it is considered to be quite normal for that age. Something happened to my son when he hit thirteen and I used to be able to predict his behavior with some degree of accuracy but all of sudden things that were once comforting to him are now distressing to him and I never know from day to day

how he is going to react. Sometimes he is clinging too and wants to be my little boy still. At other times he is very independent, he is creating new rules of interaction all the time and he is constantly telling me what these rules are, "don't embarass me by hugging me in front of my friends. You can pick me up at the movies but don't talk to my friends in the car." My world's constantly changing as his is, the rules are constantly changing. So with this experience of a teenager when I came to DOE, I quickly recognized this pattern. I think that our Government is really a giant teenager stuck in that middle school phase where the body has grown tremendously and there has been so many changes and the mind has not quite yet caught up. So there are times that where like my son clinging to doing all the things, sometimes pouring money into activities that are activities that worked in the past that no longer work and we try more of the same. Other times we try to create new rules trying to control the situation that is constantly changing and sometimes we have a good adaptation to the rules. Every once a while we stumble into something that works. The Mikini act, is actually one of those adaptations that at least a part is directed to the adult homeless literacy that works. The Mikini act, we received fundings from Stewart Mikini funding in April of last year we set up contracts with three different school districts, Dade, Broward and Orange and one Community College, Florida Community College in Jacksonville, to provide literacy training and basic skills assistance to homeless adults. The

Mikini Act takes a more holistic approach to education rather than a traditional single focus on instruction at a time when almost half of our children are dropping out of school or failing to learn to read if they do graduate continuing in our public schools with that single focus on instruction. The Mikini Act gives us an alternative. The Mikini Act provides four services in three components. The first component is outreach, was discussed earlier today that the homeless people are somewhat shy of authority. They have a great distrust of Government Agencies that exist and we send out people to gain their confidence and sometimes we have got quite Vista program in Dade County. Dagmar has put together quite a program. We have one our volunteers here tonight and they go out and recruit the homeless to bring them in for classroom instructions. The second component is support services which we consider to be essential for instructional readiness. The support services include such things as housing, meeting the basic needs of the students, housing, food, clothing counseling, day care, and transportation. Needs that need to be met before these people can be ready for instructional services and the third component of course are those instructional services which are geared at empowering the student to become a productive member of society to become self supporting. At one time, I worked as a counselor in a shelter for run aways, I did my Master's internship there and often the family would come in. They were mostly local run-aways so we get the family to come in and try to mediate, resolve

the problem and I would always ask the parents, well what is the problem? The parents' response undoubtedly, invariably would be "Johnny is the problem", and I went to my boss who was a very seasoned counselor, he has raised seven children of his own, was near retirement age and he told me that there is nothing you can do with these families, absolutely nothing until you change the way that they look at the problem. The child is not the problem. The child's misbehavior is a reaction to the situation in which that child finds him or herself. The problem is actually the structure itself and in order to effect some change in that family, you first have to help the people see the situation from a different perspective. They have to see their own responsibility, the parents need to see their own responsibility for the problem. Johnny does not act out in a vacuum. There are lot of other things going on in that situation. Once the parents, the family can be helped to see the situation in a new light then change can take place. Homelessness is not the problem, lack of affordable housing is not the problem, there are both symptoms of a greater malaise is our society. We have to look at the problems from a new perspective or we will not effect change. The Mikini Act recognizes that times have changed, we are no longer living in the world that we grew up in. When my father went to college, his education was interrupted with World War II, so when he finished, he had three children to support and a wife, he worked one job and was abled to work his way through college and save enough money to build a house before he

graduated. I am in a doctoral program now and I am struggling. I only have one child to support. I never thought that I'd be facing the financial difficulties than I have had to face in my life. People simply did better that their parents did when I was growing up. My grandfather finished high school, he never attended college yet he was abled to support his wife and children and own his own house. Today, how many high school graduates can afford to pay rent on an apartment. Not a whole lot, they can't expect to live the way we used to live and we expect to live growing up. Television however, sends us a message of instant gratification. People live in big houses, they have no problems. The Cosbys' both work very demanding jobs, one is an attorney, one is a doctor, yet they come home to a self-cleaning house. They have time to sit around and joke with their kids. Nobody is yelling at the kids to do their chores. The kids are not yelling at their parents. In the real world, half of marriages, almost half now end in divorce. Women who grew up expecting to be supported who expected to be able to stay home and raise their children, are going out to work are suffering from role overload of having to work a job at home and at work. Men who expected to be able to raise a family feel they failed because they can't support their family. So at this point, the expectations that people have, they begin to punish themselves because they can't live up to the expectations, because we are still acting as we are living in the same world that we grew up in. Men's self-worth studies have shown is based

on their income. When men are unemployed, or underemployed, that frustration correlated with elevated levels of murders, suicides, wife battering and child abuse. Murder is now the leading cause of death for young non-white males. Suicide occurs three times as often with men as with women. Men's death from stress related illnesses greatly exceeds that of women. Men and women are both caught in a bind of expectations they can no longer fulfill. Homelessness has been attributed to widespread poverty and the lack of affordable housing. Families now are the fastest growing group of homeless, 40 to 50% of homeless are now families. Single parents are particularly vulnerable to homelessness because women on an average earn 2/3 of men's salary, 65 to 70% of single parent families don't receive the court ordered child support. AFDC and food stamps combined in Florida, bring a family to 38% of the Federal poverty level. That level according to the New York Times is based on standards of 1950. The conference of Mayors last year said that there was housing assistance available for 1/3 of the people who qualify for it. Minimum wage has not yet reached $4.00 per hour. As we move from an industrial to an information society, more and more education is needed to qualify for jobs. Florida is the second, seventh rather, in the nation's high tech employment which requires the high level of skills. The Florida Department of Labor estimated in 1986, 75% of working people in Florida didn't have the basic skills necessary to learn high tech jobs. As was stated earlier today, there is a group of homeless whose problems

can be solved by housing or by giving a decent wage, yet there is that 30 to 40% who are mentally ill another 30 to 40% who addicted to drug and alcohol. The 39% to 40% who have been in jail. The institutionalization of the mentally ill continues to add to the homeless problem, over crowding of our prisons and early release of prisoner contributes to the homeless problem. The reduction in force of the military continues to contribute to the problem of homelessness, the lack of affordable health care continues to contribute to this problem, increasing numbers of aids patients released from hospitals continues to contribute to this problem, there are large numbers of homeless people who cannot be self supporting without being in something like a sheltered workshop situation. There are large numbers of people who will not be helped by housing alone. The State of Florida is in the process of applying again for Mikini funding. We have had our four programs developing very independently over the last year largely because they didn't ask for funding for my position so it wasn't filled for the first part of this projects so we had four programs developing four different curricula, we had four different methods of recruitment, some using Vistas, some using teachers, different methods of instructions and retention, so we now find we have a wealth of information that we need to put together and create a prototype so that we can create more projects like the one here in Dade, more projects throughout the State to help the increasing numbers of homeless. The homeless are growing by 25 to 30% per year. I would like to see a

curriculum which will promote self-understanding and realistic expectations for these people. I think first we need to help our government officials have realistic expectations, we need to help our children in schools have realistic expectations and to promote mental health. I think that we need to help our teachers learn how to deal with the mentally ill. There is a relatively new branch of psychology called cognitive therapy which involves learning the type of problems solving. The learning type identify different kinds of dysfunctional thinking that Dr. Fike was talking about this morning. That is something that our teachers can learn, that something that our teachers can teach. There is now computer programs teaching the identification of different types of dysfunctional thinking. Our teachers have access to these people who most of whom, 50% or more have severe depression and cognitive therapy is now the treatment of choice for depression, then it makes sense that our teachers should be trained to help these people learn to think in a way that will be conducive to mental health. Well I have told you now what I have written into our proposal, what I would like to see happen, with the future of these programs, in actuality our funding ends in June, this year. I was told right before I left that my position ends June 30 this year. There is no more funding to continue my position, there is no more Mikini funding at this point to continue our homelsss project, they have sought funding from other grants. Our teachers fortunately are funded by FTE and they will be able to continue to teach but as Bennie

Moore was just saying, funds are tight right now and I think it is really important that homeless is a priority, homelessness needs to be made a priority, homeless education needs to be a priority with DOE. I think at this point, we need to be focusing not just on the problem of housing or solving the problem of homelessness, we need to look at larger problems in society, structure of our society, disintegration of the family that was the basic structural unit of our society. As one of you was saying earlier today, can we go back to having three generation families. I don't think we can go back, I think we are looking at going forward, we are looking at needing to restructure our society when 70% of children will be living in single parent home, when 70% of children will be growing up in poverty, we need to restructure.

Secretary Bennett, our drug Czar, was talking of taking children from their parents, building orphanage. I don't think that is a good solution. I think we do need to restructure, I think we need community, one of if we remember, Maslow in your early psychology courses, the basic needs of food and shelter are needed to be satisfied first but before you can get up to self actualization at the top, you have this need for belonging and that's what is missing. I think in our society now, that need for belonging and I think that we need to restructure our society and provide housing around the community center that provides day care, that provides the essential needs so people can have somewhere to fall back on whether we need a kibbutz set up but we

need a basic change, a structural change in order to effect something that will last, to create a solution rather than band-aid a problem. So in conclusion, our Mikini Act with it's more holistic approach to education, is a step in the right direction, but it is only a small part of a larger problem that we need to address.

Thank you

Are there any questions?

(Questions)

Yes, I don't think that it is the just the homeless that needs communes, I think it is the single parents that need commune, I think that it is a lot of us the single home dwelling resident that don't have their families nearby anymore, I think in cases of crisis, of emergency, we need some sort of support system to fall back on and I think we are all too isolated in our society.

(Questions)

I don't know of anyone proposing anything like this, I don't know if there are, it is almost like, it is so radical that and we hold on to this hope of going back to time when Donna Reed was there waiting for the kids to come home from school with milk and cookies, you know and it is not happening and I don't think we'll ever go back to that.

(Questions)

Well, I think it is great where families can get along and then

there are those families where incest pass on generationally, there are those families where alcoholism is passed on generationally, drug abuse, child abuse, there is a whole lot of things that if you have the kind of support that you get from having a support system, that is much less likely to happen.

(Question)

Yes, I think they need to hear from us and I think we need to get real organized so that they do hear from us. I think that the coalitions are an established network that we need more of and we need to be more active in our coalitions and voice our needs.

CLOSING REMARKS BY MR. BENNIE MOORE

Mr. Moore, "Don't go away Janet, we are not finished with you yet but what I am about to propose is that we form a coalition here tonight and the first step is that we have to keep a spokesperson, a connection person in the Department of Education. As you all know funding for homeless programs comes to the State Department of Education whether it comes from foundations or it comes from Federal funds, it comes to the Florida State Department of Education. Now what I would like to ask each of you to do, Tri City, New Horizon, New Hope for the Homeless, we have got to coalesce and I am asking each of you between now and Wednesday to send off a message to Mr. John Lawrence, Bureau Chief, Florida Department of Education and tell him that we have

to keep a spokesperson in his Department who deals primarily with homeless concerns. John Lawrence, State Department of Education, Tallahassee, Florida and he is located in the Department of Education Center.

Janet, I met you today and I have talked with you two or three times over the last week. I think that we are fortunate to have a person like you to represent the homeless interest in Tallahassee and I would like to say personally and collectively that this group is going to be behind you, we are going to keep a spokesperson in the Department of Education for the homeless issues and that if we have to mobilize and go to Tallahassee, knock of John Lawrence's door, we are going to keep a spokesperson for the homeless in the Department of Education".

Janet Hunphrey - "I would just like to add one thing, we do have a homeless childrens program as well and I have been pushing to have us housed together with the childrens program so that we can work jointly, make a joint attack on the homeless and not duplicate efforts. The childrens homeless project have not yet developed to the extent we have and I think we can be a lot of help to them if we keep our system in place."

Mr. Moore, "I agree, I agree".

Audience, "Do you have a zip code'?

Janet, "Do I have a zip code, yes 32399-0400

Mr. Moore, "Remember, Mr. John Lawrence, Bureau Chief, Adult Education and Community Education, Department of Education, State of Florida. Get it up there and no telling, we might have John back down here with Janet in a couple of weeks from now because he is a very receptive person and he responds especially to organizations such as us. Now, while we have Ms. Humphreys up here, on the 21st of May as it was announced, and we have been discussing this after this session this afternoon. This meeting of the zoning and housing committee for the City of Miami are going to meet at 7:00 at night at the City Hall in Coconut Grove, down there on the bay behind Monty Trainers. What they are trying to do is to come up with a program where they have to certify and license church and non-profit organizations before they can provide services for the homeless. This is step No. 1 folks. You all remember what happened in Germany back in the 30's, you remember what happened in Cuba in the 50's and 60's. They start with small steps. What they are trying to do is to program the system to the homeless people out. We are going to mobilize between now and the 21st, we are going to fill that hall at Dinner Key with homeless people and advocates of homeless people until you put some money up front, don't bring

us no regulations, because these people like New Hope for the Homeless, New Horizons, Tri City, they are primarily working with homeless people with no funds so don't bring no regulations and try to stifle what they are doing and I ask each of you to come in and join with us and let us go down there and tell those bureaucrats on the 22 what we feel about this problem. Janet, thanks for coming".

Janet, "Thank you very much".

Mr. Moore, "And I am going to be talking to Letricia and John tomorrow and I am going to tell them what happened here today so when you get back to Tallahassee, you would not have to explain, we are going to explain for you, thanks for coming".
Janet, "Great, thank you".

Mr. Moore, "So if the maitre'd and the people responsible for this nice meal tonight, will go ahead and do what you have to do and we are going ahead and do what we have to do and we are going to enjoy the rest of the evening. I hope everyone is enjoying the food and at this time because it seems as if our group is shrinking. I want to make sure that persons who are responsible for this workshop because we are going to meet back for breakfast tomorrow morning at 8:30. I mean it is breakfast, no talk, just eating, O.K. and after the breakfast , we are going to have our good friend Dagmar Pelzer who is going to talk about the families

that are homeless left behind. We are going to do a wrap up, we are going to have lunch and then we are going to go back home. We are going to feel good but we are going to feel bad because there are so many things to be done. So now what I would like, as you eat your food, I would like Ms. Blanca Polo to come forward. This is a person that I have known less than two months but, is it three weeks? It seems like three years, Blanca. This is a person who is really a part of the type of work I adhered to over the years and I never beat her into the office and the only way I can beat her out is to stay there until 6:30 or 7:00 in the evening because Blanca is there and her staff is there. Blanca, I want you to give the credit from the inception of this workshop for the homeless and tell the people who the players were so that everybody can know, then I want you to tell about your staff and how you beat them to death and made them work all hours, so do the whole thing, Blanca'. Blanca, "As a matter of fact, one of them yesterday was telling me that there were no more emancipations around here and that there were no more slavery around here in Florida any longer. We have a great staff and we have had great support from the board members, Dr. Dagmar Pelzer and David Applebaum. We have got a great Advisory Board committee, we got our support staff Lissette DeLaPaz, she is our secretary. Lissette, could you stand. We have Mr. Gravelly Finley and Mr. Willis Murray. They have all been instrumental and helpful and also Mr. Bennie Moore who has been working all this time behind the scene in helping us getting all this

together. I really appreciate the help also from A.V. crew from Miami-Dade Community College who have been working here with us today and thanks to them and to you we will be able to put something together, a big report so we can go ahead and dissiminate it nationwide so we can do something about the homeless people, not only them, but also for society. Thank you all".

Mr. Moore, "Blanca, you blew it, the first person you should have thanked, is your husband because you have been getting home late every evening and Mr. Polo would you stand so we can recognize you sir, I have been looking forward to meeting you. Your wife has added a new dimension to our program and the things that really that is exception is that she came in running, it seems like she has been there for 2 months but she said she has only been there 3 weeks and things she has been able to get started is amazing and I am hopeful that Blanca that you will stay with us along time and let us get this thing because lots of times we bring good people in they stay a short time and somebody steal them so I am going to get me some of these guards from the Radisson. You know this is the best guarded hotel in the world. I was in the room up there tonight and I saw the security riding around and riding around and riding around and I thought I must be back in Liberty City. So to the Radisson hotel, you have been wonderful hosts, in fact you have been such wonderful host that I hope that I hope that I can meet with Esther Colado on Tuesday or

Wednesday and sign a contract for the Southeast Region Council for Black American Affairs to meet here in March, 1991 and we want to bring in close to 500 people from throughout the Southeast region of the United States to this hotel. These people have been very, very considerate, they didn't try to rob us. The help has been very considerate, they made us feel really at home, we have our rooms here tonight. Don't take no linen, don't take no towels and for God's sake watch your telephone bills. I am very happy. This activity as well as the whole project that Ms. Polo direct is a result of the grant from the State Department of Education, the State of Florida and is known as a funding program under the 321 Funding Act, and we hope that this program will be in effect for three years on June 30, the first year ends and we are hopefully that we have the second years and the third year and by that time, Blanca, you would have done such a good job that Miami-Dade will then make this program a part of the instutional support with hard money so that is what our objectives are and we can continue to have the support of all of you who are here tonight and who were here today, that we can do that. Not only are we concerned with the plight of the homeless, we are concerned with the plight of the economically and educationally deprived, we are also concerned with the people who have problems with English, when English is the second language, all of those things and we add it in next years's funding four more different areas. We are going to be here and I want you to continue and I hope you feel good. Those persons

from Tri City, New Horizons, New Hope for the Homeless, and Dade Public Schools you are the first ones, we just now started and Blanca said, we plan to do two each year on each of the topics. It is not written in stone that we can't do three or we can't do four. If this homeless project continues to escalate, we need input from you. I would also like to say, thanks to the members of our Advisory Council for the Southeast Florida Training Center for Adult Literacy Educators, that's the official name and some of you were here today K.K. Gray, Gabe Reed is here tonight and so we thank you because you have been giving us direction that we need, you are evaluating our activities and hopefully that we can continue so tonight is just beginning, have a good dinner, the hotel is yours.

Thank you

Dr. Melcher & Dr. Gonzalez tape

Blanca - Hi, now we are going to have Dr. Melcher and Dr. Gonzalez, they are both from the New Horizons Mental Health Center and they are going to talk to us about the medications, the psychiatric needs of the homeless people and they are also going to talk to us about their experiences with some of their patients of this center. Also we try to get check out time to extend beyond 12 o'clock so the best we could do with the front desk operator was 1:30 so we all need to be checking out at 1:30.

I hope we will be out by that time after lunch.

DR. GONZALEZ

We would like to welcome you in the name of New Horizons Mental Health Center in the name of Dr. Melcher and myself. We will try to give you some basic information of the homeless population, some of the characteristics we have found among these patients. Nationwide, they claim that might be between 600,000 and 3 million people but these counts are, probably get different counts from different sources but in general, the homeless population is very hard to be counted for. In Florida they claim that 1985 that probably the population between 10,000 to 13,000 and the sub groups are composing this population, we have divided and probably 9 sub groups maybe other sources will divide them in even more sub groups but these are the ones that our experience show are the most common ones. First is the older male client who is transient, who has been probably in the picture for many years and these people are almost professional homeless people, they know where to stay, they travel the country up and down according to the season and they are very well informed locally where to go and where not to go. Second which is the one we are more concerned with is the institutionalized psychiatric patients, these people in the 1970's were released from many hospitals throughout the nation and were supposed to go

to a specific sort of a half way houses and other boarding homes and facilities and shelters but because of the lack of funding, they end up becoming homeless. They are probably the most , the one that has less capability of adjusting to the community and they have experience, probably a sad experience with many of the organizations like the mental health centers, state hospitals and at times they shy away from our organization because they have had sad experience in their minds. We have a group of the youth run aways, throw aways, we have in this group probably as a specified by youth, these are youngsters you will not see many of these in our organization but one or two listed because for sure are part of the composition of this large homeless population. The families #4 families who have exhausted resources we have seen more of th at and I think that in the future the programs that we have, have to be more geared toward families, these are families that because either a bankruptcy or serious illness in the family maybe the main provider is out of the picture right now, we see families composed with not only mothers and children also as well as fathers. These people as a matter of fact are working and they make very basic salary to maybe eat and cover for some basic expenses but they cannot probably provide enough funds to have a home. #5 is the mentally and physically disabled, but they have people have low income and they actually cannot live by themselves with the income they are being provided with and they end up becoming homeless. We have seen more of the #6, the abused and battered women and they usually go to a women,

abused women shelters who refer them to us and they also go to places like Salvation Army with their children, sort of trying to stay away from the abusive husband. Victims of alcoholism always have been part of the course of the homeless population but we are seeing only the alcoholic himself but we are seeing other members of the family you know like, spouses and children who actually become like a #4 families who have exhausted resources and they also become homeless. Here is south Florida, we have the problem of the illegal immigrant, you remember in 1980 we had more than 120,000 people coming via Mariel from Cuba and recently we have a great immigration coming from Central America. Many of these people actually have no way of surviving because they have at times no resources, no programs to go to and they have no work permits so they become very much, very soon homeless people. The victims of disasters were included their natural and man made for e.g. you know there recently was a situation of arson in the community and many people actually who live in those buildings have to be placed in the streets in some shelters and some end up becoming actually homeless. We are concerned with the great percentage of mentally ill people and the homeless population, we refer to them as HMI - homeless mentally ill and it seems there is a high percentage of probably from 20 to 50 percent and these people actually many of them have the background of being institutionalized in the past. Now we also seen people that probably could be included in a different sub-group, these are individuals who are mentally ill, but because of the Baker Act limitations,

Baker Act is the law that regulates who can be hospitalized, psychiatrically and who cannot be hospitalized then these people end being on the street hardly treated as out patients when they actually could benefit from an inpatient hospitalization but not because the law protects them, we seldom see them hospitalized so they are reinforcing this group and increasing the group of the de-institutionalized psychiatric patients. The individuals who come to us already have many medical problems which many of them don't seek any kind of treatment. Among them is tuberculosis which actually is coming back, AIDS of course everybody know about it it, malnutrition, infections in general respiratory infections primarily, skin and hairy festations primarily the major problem is that is becoming a dual diagnosis is substance abuse. We also of course include here among the infections, venereal diseases of all sorts. The substance abuse is the major problem and might be as high at 30 or 40 percent of the people we are seeing now a days so the patient that comes to us at times come intoxicated and is difficult at times to evaluate the different shape whether it is a symptom of a mental illness, the type of psychosis or whether it is due to the intoxication with substance so it is almost mandatory to convince these people to go through a drug screen at times you know to make a different association, and then we have, the problem - what do we treat first. Usually we refer the mentally ill who have substance abuse problem and happens to be intoxicated, we would like to have them go through some process of detox and then

when this problem is cleared, then treat the underlying psychiatric problem. What happens that when we send them to the detox centers, they usually after a few days, request a release and we don't see them anymore. On the other hand we have the mentally ill patient, who also uses substances and the substances we see more are alocholol, crack cocaine or any other forms of cocaine and marijuana but at times there are treating themselves with these chemicals so many patients who are depressed or anxious even the psychotic ones with a floated kind of hallucinations and illusions , they try in a way to treat themselves with substances that and they become a secondary problem. I think Dr. Melcher want to talk a little about the diagnosis but I want to say something about characteristics we have found among this homeless population. As you know living on the streets creates a lot of problems for anybody . One thing you can count on is lack of security and unpredictability. These people have the characteristic that they are highly immobile so they change locations at least for their own safety, this is probably part of the defensive mechanism they use. They try to blend very much with the what is going on around them to the point that some of them almost become invisible. We have seen many of them who try to walk all day long up and down without any place to go, some that will sleep during the day, like instead of going horizontal, they don't sit down, they look like they are sitting or standing. We also realize that they try to get minimum information from others and avoid the, close inter-

personal relations. When they arrive e.g. in the area of Miami, the first they find out through other homeless people, is where to go to have a bed for the night - know where there is a shelter and where to go for meals. They avoid evidently some sort, I mean all sort of problematic situation. I think they are peaceful in general, they try to avoid being noticed especially by forces, the police because the great process of criminalization of the homeless, you know when they are in trouble, they are not usually referred to us for help and assistance, they are referred to jails and from there , they are referred to us. They usually are guarded most of the time so if you want to assign a diagnosis at least a personality, disorder diagnosis or an adjustment sort of disorder, adjustment reaction, you can always find one in the book and the DSMB, which is a book called diagnostic, statistical manual. We have now the 3 which has been revised and there is a chapter of ICD9 which is an international code for diseases put by a an organization called World Health Organization.

They have in general a great capacity of adaptation, so there is not always lack of strength in these people, they are at times very highly adaptable, they have adapted to new places everyday, to new people everyday, new environments, situations and they also have the problem that most of them have to confront that they usually think twice before going to an agency like a mental health center for example seeking help because of their past experience also the fact that they lack transportation and

they lack identification and one pattern we are seeing even who have identification and wants to go through the criminalization process, the police, the authority at times keep this identification away from the client so we have to go through a process of getting identification for them again and it is either more complicated when you deal with aliens, you don't know whether they are illegal aliens or not - of course we help everybody. So I would like to have Dr. Melcher come here to talk a little about diagnosis and then probably give more time to the treatment aspect of the problem.

DR. MELCHER:

Well, good morning everybody, I want to have this opportunity cause I feel also that I belong to your area because I have teaching for almost 35 years and I have been teaching recently in the Institute of Psychology, Psychopharmacology to the future P.Hd in psychology and you are going to be surprised, I remember that sometimes, I have been talking with my student about little things, personal things and suddenly one of them have been telling that they feel that the people have been persecuting them or they sometime or the other they hear voice etc. then if we can find in the future, people who have this type symptom . I think in your case, you have to be aware that when you are dealing with homeless, at least the practical thing for you would be how I am going to know if I am dealing with a schizophrenic or

manic depressive or any other disease and at least you have to be familiar with the medication they are taking, other wise you are going to be a little loose, don't matter how much you try to teach them, you are going to see a lot of problems. Classification of a mental disorder, one that you can write every thing that I can give you. Essentially, we had to study a lot, many a years trying to understand the different mental disorders and we are trying in ten or fifteen minutes to give you the resume and you have to make a good effort trying to understand. Let us say that we have different diseases that have classified since the time of Greek people - you remember the time when we have the Greek people that were trying to classified and organize different mental disorder. Remember historically, many people including our days today, how many ideas the people had at the mental patient or the people has convulsion were possessed by demons and this way they were treating these poor people in very bad way. They were sometimes put in the fire or they were killed because the simple fact that they were hallucinating etc. We have other area in the planet that they found that these people were very famous people because if they were able to hear voices, they had to be in control with God. But still we talk with our people in our century, you will see how many idea people have about mental diseases and we have to deal with that situation when we are talking with maybe homeless and maybe who has a very poor education or that the background is not very good or sometime we talk with some staff that has different ideas about

the mental disorders. What we know today, in our time is everyday we know about different factors that are conducting to produce a mental disorder. Because when we are working in New Horizons and we belong to the Cashmier Area 4, we are talking about Liberty City and for some reason, we have the high percentage of schizophrenic patients. You compare it with Coral Gables or Hialeah or other place, we discover that the low income population, the people who are suffering nutritional deficit and the people who are also in a condition that they probably are going to create some type of paranoia idea that people are following them, or when you talk with immigrant people, from a country, like a communist country, that have been constricted their freedom, you are going to see the same type of paranoia. We have to confess, we the Cubans have that type of tendency always to think that somebody is listening to what we talk etc. Exactly what I am going to bring you is what happen now that Dr. Gonzalez mentioned about the new classification of the...book. That book is going to change but at least you have to have the idea that in the past we call a woman that was in the 45 or 50 and suddenly was very depressed and was hopeless and change in the family was very astonished about the condition about the lady that in the past we used to call evolution of melancoly a type and now we say no this is a patient that according to a new terminology is major depression with melancoly but it is the same thing. All I want to bring you is names that maybe are going to change according with and I think some interest to also to sell

the book because it costs about $50.00 and it will take two or three years to change the book. O.K. the first disease that I want to take into consideration is the schizophrenic. Schizophrenic, that means split personality. You can see the percentage that we have, there are 13 to 37 percent from the homeless. When we study a general population, we study every 100 people, we have 1 person that is going to have that condition. This is a disease that like similar to cancer, we don't have cure for them in this moment. We know the symptoms, we have been elaborating in different theories, I mentioned the economical factor or the people will say no it is their families that create this schizophrenic - the patients are going to be disorganized. Other people say they are oriented to more chemical or medical orientation that will say no that we will have to study the brain and it is true that there are some substance that we have in the brain - the name is dopant - that when we have an increase amount of that substance for any circumstance, that person is going to develop psychotic behavior. We are talking about people who are going to have hallucination that they see things or hear voices or see things like visions or say sometimes that somebody is touching them. Sometimes they have illusions that means false belief is what they think that they have been persecuted or somebody is controlling their minds through certain electrical specific condition that is in the house etc. Then schizophrenic have been studied for many years, for hundred of years what we know today is a person that have essentially thinking disorder

and they cannot function very well. These people you are going to see that usually their condition start at the age of 18, 19 is what we call pre-cox dementia because we are going to see the symtoms that we see in our old people in the house that they start hallucination with delusion etc. We are going to see the very similar thing about a person is in the 18 is what we call in the past pre-cox dimentia but now we are talking about schizophrenia - a new terminology. We have the incidence is very high as you can see in the homeless - when we are talking about 11, 13 to 37 percent we have to calculate that is a big amount. Probably, this patient has been discharged from the hospital and they have been in the new moment remember that about ten years ago we have the South Florida State Hospital we had about 4000 to 5000 people. When you go there now you will see only 400 and where are the rest of the 3500 - they are out here out in the streets talking to also the school or any place and this is part of the homeless that we have plus the other group that Dr. Gonzalez mentioned before. What are you going to do when you are facing or you are trying to teach these patients or if you don't know they are patients, or you don't know that they have certain disorder, we give you some clue that you have to take into consideration. The lifestyle is important, you will notice #1 that they have not been able to function. Practical, maybe they never have been married or if they have been married it is a big disaster because these people remember when they are working, they are listening to voices, they have to kill somebody or

they have to kill themselves. It is impossible to work and to function in normal level. And we are going to see the four A. The first is the association - these people are jumping from one subject to another, it is very difficult to follow, they conversation, their speeches are very - the thinking content is very difficult to follow because they are talking sometimes unrealistic topics you cannot follow, they are talking about the temperature today, or you are trying to teach them about supposedly the weather, they are talking about other things. You are going to see the effect of these people. When we are talking about funny things, we laugh and we are happy. When we are talking about sad situations in our face, you can see the depression, the sadness, but these people, they have very inappropriate effect, sometimes they smile, when they are talking about funeral of the mother or something like that and also you are going to see that they don't have too much expression in their face and we are talking about blunt effects or flat effects. They are like masquerade and you are going to see this type of people, then you will see #1 is effect and also the association. The other thing is going to be the autistic behavior. Autistic behavior mean that they are in their own world. These people, you know sometimes you are talking to them and they are thinking about other things, they are complete out of their reality and we have the third factor you have to see and we mention the effects, the association and autistic and finally ambivalent - mean that these people usually have two opposite

feelings at the same time. When we read the book of Freud, we are going to see they have hate and love at the same time and they have the same thing you can apply in every circumstances. When they are talking if they want to work, say I want to work but I don't want to work, the opposite. This is the characteristic. Also you notice that they are taking medication. They are bringing bottles, you have to be familiar. In the third part Dr. Gonzalez is going to refresh your memory about different medications including we brought some paper that is going to be helpful to you because in it we mention all the medication that you need to be familiar - the schizophrenic usually have to take doses of anti-psychotic medication that are going to control their thinking disorder and this medication fortunately, produce a lot of side effects and is good in certain way because it is going to control the third step. O.K. these people usually have very hostile anger and violent, don't be afraid that they are going to be violent. Probably when you see these people, they are medicated but usually without medications, people show aggressiveness and this is the first thing we have to control, somebody that want to kill or beat somebody. The medication is going to control the situation in hours most of the time. It will take 4 to 6 hours to control this person because we have injections, we have medication now that fortunately are able to control this attitude. Also we have to control what we call th e thinking process - the hallucination, the delusion that have been bothering these people and they are suffering because except they

will hear from Dr. Gonzalez, including what we call the long acting medication and he will explain to you that. Then the schizophrenic also have a little section of one disorder that still is the limbo because we are going to see a person that at the same time is able to transmit his feelings because usually with a schizophrenic, what you are going to see is like, they have a big war between you and him, the patient - try to follow and you would notice the clue that I am going to give you after five minutes talking to a schizophrenic, you will get a headache immediately you know because you know you try to follow what they are jumping from one subject to other and you always must try to have some aspirin with you, or tylenol and be prepared and you feel too much affected, it if very difficult, these people put a big wall between them because they are complete out. When we have another group that we call mood disorder, thinking disorder schizophrenic, but when we are talking about mood disorder, we are talking about these people, they don't have hallucinations, they don't hear voices. We are talking of these people who are suffering of type of, you can follow them, you feel for them, you almost cry when they tell you how depressed they are, at least you understand the attitude certain people have. We have to divide major affected disorders when we talk about the bypolar and we use to call th em manic depressant, very important for you to recognize. This is a very important for you to recognize, this is a different entity, you cannot relate , I mean schizophrenic and manic depression are completely different.

They have different entity, different medication and what we see in this people, is that they have a history and usually it starts at the age of 30 - it is a little late than the schizophrenic. Remember I told you since the age of 18, 15 sometimes, when we see these people that they are acting normally, function very well and suddenly at the age of 30, we are going to see a pattern of behavior, sometimes they are very elated, they are very happy, hyper active, talk so fast that sometimes, you cannot follow the velocity. They talk about 150 words per minute and it is amazing. They have what we call flight of ideas, it is a little different of looseness of association. The problem is that these people are so sensitive that they are probably very, for example, if I am a manic person, I would be aware of the applause and I would start talking about it, maybe these people are applausing are very happy and this and that and suddenly if I see the television, we talk about the television, these people jump from one subject to other but in different fashion. I mean what they talk or what they say, the sentence is pretty normal, you can understand or follow, the difference with a schizophrenic talk, they use sometimes two or three words together a mixture of words or they sometimes, they act so psychotic, so out of reality, that there is no sense what they tell you. Just remember the headache, but with the manic, you are laughing because these people are so, usually they are very intelligent people and I want to tell you something,they say the organic people, people who have organic conditions, maybe people who have been taking a

drug, who have been alcoholic, people who have been working with metals, they have affecting brains, that they have a lot of problems with reference to the memory and the judgement, but when you talk about the rest of the diseases that are, you know the other rest of the mental diseases, disorders, schizophrenic, manic, don't think that these people are stupid or they don't have intellectual function. You are going to see lot of doctors who become schizophrenic because, you can finish maybe our career and then suddenly you start having all the symptoms, then the intellectual function is most of the time preserved, they are very well oriented, they know what is going on. If you talk about what is going on in Europe, they are aware, they read the newspaper, they know. I know that with the people that you are going to deal, are people who don't, maybe know how to read or write but they know, you can talk to them. The only thing is that you have to be aware that it does not mean that because you have in front of you a very crazy person, if disoriented, may they say, they know the name of the President, the intellect function is preserved and the affected disorder as I said before they are all manic depression, now we use a new terminology, we call bypolar. The bypolar means that this people in certain months during their lives they are so hyper that they are going to see a person that is spending a lot of money, you know buying things, giving gifts to everybody, very happy trying to control the whole situation, the whole world, trying to call the different Presidents in China, the Soviet Union, talk with Reagan

or Bush or whoever. They think that they have the power, have ideas how to solve all the different problems in the whole world. And you know, if you are a rich person, your manic is no problem, you have to spend a lot of money but this family that are poor and you have a manic, these people have to admit this patient immediately, because they are going to spend a lot of money, you know calling, the telephone bill is going to be so high. These people are usually not in the very manic state, they become so psychotic, they can become violent. But usually in the first state, they are so funny people that you will laugh with them, but remember with the schizophrenic, you will have also a distant. Then the manic depressive, you will see what medication we use, the thelium, Dr. is going to explain that. We have the other contra party for certain people who become very depressed in their lives and then we are going to see an isolated person, we throw in their room, they don't want to relate, have social activities with anybody, they have a lot of physical complaint, they cannot sleep, they have insomnia, poor appetite, they are going to loose weight, they are crying most of the time, they don't wish to continue living and then we see the cycle is what we call bypolar and the pass manic, and the hyperactivities, depression is in the other state. We have medications for both states. These people most of the time are manic, or most of the time they are depressed, then we have to use the unipolar and they are referring to a person that only manic or depressed. You see also in the second part another depressed condition that are related with what we call the cycla,atoc disorder and we have to

remember they are all neurotic patients that we mentioned in the past, to be very depressed, but we are not going to see the manic state, we are not going to see psychosis. It is a person that may be has some conflict when they were little child and have been bringing some depression after many years and they have to have more different treatment. But you see the statistics show that when you are dealing with homeless, you are going to find 10 to 29.5% of people who are suffering of mood disorders. You can compare, it is true that a schizophrenic have the highest level and the mood disorders is very important. Keep in mind all the symptoms that I am telling you. The hyperactivity,the history, they can say "I remember when I tried to solve the problem of Vietnam", what did you do? "Well,..." then they are going to tell you, they like to write page and page, hundred of page and if they have been keeping all this record, you are going to see these people with a big handwriting, they feel so famous and remember that, remember Tony Orlando, the singer, the famous man that was calling yellow ribbon around the tree, remember, he was a manic and when the moment he was more famous, suddenly he wanted to practice, they finish usually in the night clubs around 1 o'clock or 2 o'clock wanted to continue practicing and all the orchestras said it is 6 o'clock in the morning and we are so tired, he say "No, no", he was full of energy and he was so full of energy, he would say he was going to play sometimes in two countries at the same time you know - he was really talking nonsense and they have to admit him and now he was talking on television and advising the people, you have to take the lithium,

you have my same condition. But these people are able to function but they have to have some control about the medication. Remember now the third group that we have there is the personality disorder that represents 18% of the people that don't have any home. These people usually has a trade, they have problems in their personality. We are going to see antisocial behavior, persons since the age of 12 or 13 have been a stealing or in group have been doing things against the property of the people, have been robbing banks, have been in group, in gangs. We can see a pattern of that type of behavior. Practically, unfortunately, we don't have treatment for these people. There are no medication that can control that. This is a defect of the personality since the earlier stage in life and there are no theory or nobody can say in the schizophrenic, say now we know that excessive amount adopamin can produce a schizophrenic or we can say well now we give lithium carbonate to the manic people, we are going to control that type of hyper activity but we don't have that type of situation with a personality disorder you are going to see this type of history problem with some people who we need to handle. Remember they are in the cuchoo's nest, the picture, you know what happened with Nicholson, he was really familiar, was a person who has a personality disorder, but by mistake he was admitted in the hospital and what happened is that he put the hospital in different perspective because the schizophrenic, they don't have ego, the ability to organize so well the situation. When you have one anti-social so socio-pathic personality admitted in the hospital, they are going to

control the poor schizophrenic, they are going to become the president of the whole floor and they are going to ask for privileges and you are going to have a revolution and sometimes we see the vice versa, we see the poor people who have psychiatric conditions, they have been in jail as Dr. Gonzalez mentioned, is said to be in the proper place, I mean the hospital and they are in the middle of people who have more delinquent situations. The other four groups that I want to mention is the anxiety disorder. Anxiety disorder is a condition that has been under study for many years and many of you have been reading about what Freud mentioned that it is an unresolved conflict that you have been dealing with a person that for some reason had problem, maybe at the age of 6 or 7 or 8 years and they have been unable to solve that situation and they swallow that thing, it is a big secret that they have and their body is going to react. When you have a mental thinking that is bothering you and you are not able to sleep, it is because you have some conflict that you have been unable to solve. Can be something personal, something that happened many years ago. When we have this situation, the body is going to react and we the superena gland that is a gland that is in the upper part of kidneys going to secrete norepinephrine to the body in order to prepare the person because sometime we don't know, sometimes we forget why we have to be nervous, we are afraid to take an elevator, or we have phobias or we cannot be in a group of big people on a small space and it is because we have something that we did not know exactly

and you have to talk with the psycho-analysis or the psychologist to solve that situation. Then what would be the symptoms, we are going to have a person that has a restlessness, very nervous, very tense all the time in certain specific situation. We have person that maybe to the obsessive compulse, they have to clean, wash their hands two hundred times or the person that has to do a ritual everyday, you have to put books all in order you know, and is a person who is suffering because of that situation. These people usually need another type of medication, and the medication we use for a schizophrenic if you by mistake with a doctor give to a person that only have anxiety, we are going to create another schizophrenic and we cannot give to a normal people or people who are anxious or depressed anti-psychotic medication and this is something we have to keep in mind. We are doctors, not God, we make mistakes and sometimes least you can detect something, you are dealing with the client, you are trying to teach them.

If you notice certain things, you are the first one who are going to send us a message saying "Hey, you know that your patient, my client or my student is doing this and that, or he told me this and that", in this way we will know, sometimes we don't know if the medication, we see practically the patient only maybe one hour in one month and the people who are dealing with them is a family or a relative or in the case of the homeless, probably you are going to be more in contact with the patient. In one day with the doctor, then we have really to be realistic

as far as that. You have give us feedback about that and the anxiety disorder, we have also people who has had post traumatic traumas. Remember what Dr. Gonzalez was mentioning about these people who have been immigrants that came from different countries. People who came from other states is very amazing what happened. They are not familiar with the different situations in this area e.g. in Miami e.g. you are going to see a poly group so many multi ethnic group and sometimes we are confused because we don't know or we don't understand the behavior of many people. I remember I was a resident at Jackson Memorial Hospital and I remember that the doctor that was on call was an American doctor. He came from Ohio. He was not familiar with certain types of African rituals or African religion or Afro Cuban religion and a woman came in complete dress in white and she was doing certain you know, signs and the lady, I remember he started writing because he tried to talk with the woman and she was not able to speak English. Then we have a barrier conflict. But you try to use all the knowledge and say "Oh, this is bizzare behavior. He was writing in the chart bizzare behavior because she was dressed in complete white, she is doing certain signs and she was crying and then he did not want to waste time. Say no it is better to admit this patient, she is crazy and the next day when we try to interview the patient, the patient said "No, you know, almost a week ago I became a Saint, I belong to the African type of Religion, that is why I am dressed in white", I asked why she was crying and she said,"Because my mother died in Cuba, was

not able to be with her when she died". and what was the signs - well, it was the Christian signs but doing some rituals that I have been learning". You see how much the confusion can produce a effect and you can make a big judgement and make a mistake and we need more beds in the hospitals, not to admit people that really don't need to be admitted. Then what we have also different conditions that also represent a good amount. When we talk about anxiety disorders, it is the less frequently, in the homeless population. It means that you are going to see once in a while somebody who has this type of anxiety and may be conflict that he was not able to solve but this is maybe minority of the percentage. Remember that we have to deal - most of the patients are going to have, may be they are normal, we can call normal you know, we are going to see about 30 percent schizophrenic and very close to 40 percent people who have been taking drugs or alcohol for years and years and this is the other group, but the anxiety problem - not many. You find somebody is going to be very interesting because this people are very verbal, you can communicate with them very well. The group of the substance abuse that we mentioned crack, alcohol, marijuana, they are really very high in the experience that we have here. We mentioned 30 to 40 percent. Unfortunately, we are dealing with this situation, we are going to see people who are in the street because they have been taking alcohol for many years or maybe they were married but they lost everything in their life, their job, they lost the ability to conduct the home in good situation

because they were drinking most of the time, they were beating their wives or also spending money buying medication or to buy drugs, buy alcohol, then this is something that you have to be aware of this disease that are so important to be familiar. I want to do a resume. We have another five diagnosis, but you really don't need to know that - why - because you know they represent maybe little things that happened when you were a little child and you are not going probably to see so many children in the group of your students but it is because we make mistakes and there are some discrepancies, there is group that you see that they are acting a little strange they resemble people who are schizophrenic, you will see sometime a little effect or flat or blunt effect, they just from one subject to another and you say that "I am dealing with a schizophrenic" but they are able to talk to you and you feel sorry for them and you don't get headache after five minutes. They say, "What is this group that we call a schizo affected disorder"? It is group that is just in the middle. What we may be thinking is that there are some genetical factor remember many of the mental disorder we consider, there are some inherited situation, congenitial we got something from our great grandfather. When you start a family history, you are going to see a pattern of the great grandfather was is a psychiatric hostital, the grandfather was or the grandmother was in a hospital, my mother is acting a little something strange, you say that she hear the voices of...then she started talking nonsense, then you can see the family orientation

is very important, you can see the social aspect, how it can produce this type of situation that I mention before while we have so many cases of schizophenia patients in this area and the social aspects are very important there are other theory mentioned about - a organic condition, the medical people say no, it is the brain that wandered for use of certain amount. We are talking about chemical substances that we have to use. We have to use chemical substances to counter arrest the effect of a chemical disbalance. There are other people who are more in favor of that the mental disorder is a some conflict that was not solved in the earlier stage of life. And other people, we consider that the social and economic is very important, and other people say , "All of you are wrong", let the people to be crazy, this is their right of the people and this is a very wonderful experience to feel hallucination this and that, the type of psychedelic theory. I don't think that you are in favor of that theory cause you know, we don't need that in Miami, more people - the mental disorder is normal. In general, what we have to be familiar when we are dealing with people who are alcholic, you will see all that these people have organic conditions that this is a group that I forgot to mention. Organic brain disorder - this is the last group because we have give time to Gonzalez to attack the medication. The organic condition is damage in any part of the nervous system. Then we are going to see five aspects that you are going to detect the same way that with the schizophrenic you remember the four aids,

now we are going to have five aspects that you are going to see in the people have organic problems, damage of any part of the nervous system that can be caused because of drugs, can be the cause of alcohol, it can be because of physical damage, trauma, an accident, can be part of the history of the person or, if the person was working and maybe, I had a patient who was living with lead at the time and he has little piece of lead on different areas of the brain that come for the use ... a lot of symptoms - a symptom that can be also hallucination, voices or can be delusion ideas of reference etc. These people are going to have five aspects which we call JAMUS, judgement is going to be affected, these people are confused, they don't know what they are going to do in certain specific moments and their judgement is very poor. We are going to have also the effect is going to be little - they change the effects, very similar to schizophrenic inappropriate effects etc. Then we have the memory impair memory especially the recent memory, they forget what they wear, what they had for breakfast this morning or for example example what or where they put the key of their house etc. They are completely confused in this way - memory. Then we have last IO, if I intellectual, you are dealing with a person that may be used to be a professional etc. and suddenly it was a professor of mathematics or may be was an accountant and you how much is six and four and they say twenty-one, I mean they are confused, they are making mistakes in the intellectual area not matter if they had a diploma or whatever, the area of the brain that has been

affected is affecting the intellectual function and finally O means orientation. They are disoriented to person, they don't know their name etc. or they are disoriented to time, they don't know what day is today is who we are having, our mental...when we talk with a patient to do an interview get information to make diagnosis, we have to conduct an interview and one of the questions, is what day is today you know, we have to know if they are oriented and sometimes they are disoriented to place, they do not know where they are. Where you are here, we are in the hospital, and they say "We are in the theatre, we are in Yankee stadium", I mean they are completely disoriented. Then we have JAMU - judgement, affect, memory, intellectual function and finally orientation. The five things that we have to see in this client that you are going to have that no matter how much you try to teach them you know, talk, how to or write you are going to see that they have this area and unfortunately you are going to have more work for them because remember with the schizophrenic maybe they are sharp, they are oriented, their judgement maybe sometime poor but they are able to memorize many things but with the organic people you cannot, then you have to be realistic and you will say you know I was taking cocaine for ten years and then heroin, five years and LSD two years, these people have a long history of substance that have been introducing toxic effects in different areas of the brain and this is a permanent damage. So when you remember that the neurons that settles on the nervous system never are going to be duplicated and they are going to be

reproductive. Then unfortunate, when we have a damage in the brain that area is going to continue damage for the rest of the life. Then we have to be realistic as far as that. What you are going to do is very hard cause you are going to deal with not only with people who are harmless, the homeless who have been bringing their mental

conditions or Dr. Gonzalez mentioned before, is people that maybe have the trait or used to have little systoms or as soon as they become or any circumstance homeless, they are going to develop new mental problems, they are going to develop certain diseases that they were masquerading in the years for. Let us see if Dr. Gonzalez attacked the drugs, the medication that we used today and at the end you will be able to ask us any questions you want.

Dr. Gonzalez

As you probably know, it was not until 1950's when we acquired the the first major tranquilizers as a matter of fact, before that many medications that were used for other purposes were tried in order to fight the psychotic symptoms among them were medications like reserpen which is a medication which is used primarily to lower blood pressure. So in the 1950's we acquire the first medication by the name thorazine, probably everybody heard has heard of thorazine and seldom use it anymore at the present time because we have more specific drugs. By the way we use drugs in the content of medications, not in the content of

substance abuse. The major tranquilizers and I gave you few names, I dont know whether you... we had names like the havo narine,perexine, thorazine, emllorick, stellizine, etc. the medications that we are using as major tranquilizers, we usually have to be concern about their intrinsic value in the streets, so the first thing we do when we see a client was a homeless come seeking medication, we would like to be sure that person does not live in the streets. On the streets, it is dangerous for them to use medications not only because of the intrinsic value that they may be robbed or mugged or they may exchange it for other things we do not want them to take like crack cocaine, so this has a monetary value in the streets because they are very expensive by the way. Also the fact they they can induce some side effects which can be apparently serious so we would like for these patients to be placed in shelters before they take one pill from us. So they can spot any kind of side effects. The side effects are probably major problems and has to do in a way with the non compliance that these people struggle with, they prefer not to take medication because the side effects, and these are including among them, maybe over sedation you know a dry mouth tremors or a stiffness you know. Muscles at times especially in the neck or the eyes at times they pull one way and you know they feel they are going to choke so also in male patients, we find that when they take medication for a while, they complain about their libido and they want to stop it or they may even have some pressure from girlfriend, somebody to, I say some could be

boyfriend or girlfriend depends on the sex but they usually have some pressures sometimes from others to leave the medication to abandon it, so we are very careful when prescribing medications and we have to keep in mind that at times we have to prescribe number 2 category to so call anti Parkinsonians. The medications in the second category are the Parkinsonians actually counteract the side effects that I was mentioning from the major tranquilizers. Some doctors prefer not to prescribe them and wait for the side effect to appear but the fact that these people are not observed every day, they are not institutionalized, at times we prefer to give a small amount to go along. The interesting thing about the Parkinsonians and we have a couple of names are artene and cojenten is that they can function very fast especially in the injectable form so we see patients with this side effects who seem that they are going to die and you give them a shot of cojenten and probably in five or ten minutes, you know, they disappear entirely. Also our clients are very smart, they know that they artene or cojenten can make you high so many of them come saying that they have side effects when they actually do not have them or because they are only taking th e cojenten and skipping the major tranqulizer. The major tranquilizers will tackle many of the so-called positive signs of the psychosis or schizophrenia in particular all the ones that Dr. has mentioned, but they are some signs for so-called negative signs for example being withdrawn from others that the major tranquilizer not necessarily is going control, we see that the, symptoms that we see more response to is things like delusions

and hallucinations and the improvement and their behavior as well. One thing for you educators to know if you are teaching somebody you know, because of the information given to you by Dr. Melcher, you probably can identify some of the symptoms in individual who may require referral to our agencies for treatment with medications. On the other hand, we also would like you to be aware that medications are going be probably exhibiting some of the side effects that we mention and the first thing to ask whether they are taking any medication and refer them back to the treating physician. Now the anti-depressants, you see more and more, we see more people depressed in the community and under the heading of depressed disorders we have also of course, the by polar kind of patient who might be very much at times depressed, at times manic but we also have the unipolar who is also depressed. One interesting about the bypolar patient is that or the unipolar whether it is manic or depressed is that they may require medication by the name lithium and we will talk about it later but also this lithium at times have to be combined with another two first categories. Say we have a patient who is going through a crisis of mania and they may need very much at that time a major tranquilizer first and the lithium to be added later on because lithium is like a mood stabilizer, it does not do much at times by itself. On the other hand you may have a patient who is bypolor that at times is depressed, you see them the moment they are depressed, you might have to add an anti-depressant or may be just a unipolor

depressant, you have to use for sure an anti-depressant in their case. We have a many names here in this category, I can mention a few - panadol, prosaic, we have the supremine, the synic one, synic one is very much used in our clients because having a little side effects and it can be used also for the treatment not only of depression but also for the over anxiety as well. I did align prosaic, the problem you know, you have to learn about them, you have read about it and is probably the newest anti-depressant on the market. We will find that there are some clients coming to us requesting prosaic, especially female clients and of they tell us a story that they know that they are depressed and usually they are obese learn this for some other clients that when they take prosaic, there is a tendency for these ladies to loose weight so many times come around clients saying that they are depressed and they may not necessarily be requesting the medication prosaic but in the cases we have given prosaic which is usually given only in one dosage in a day - 20 milligrams usually, is an excellent anti-depressant and different in the chemical structure from the ones we previously knew. One of the problems we are having with anti-depressant and this is another thing for you to be aware of when you have a student that is being treated with anti-depressants. For the first couple of weeks, I would say ten to fourteen days, they will not feel no better as a matter of fact, times they have the side effects primarily the dry mouth, the sedation and then they abandon the medication so may you will see one of your student who is not

concentrating as well as he should when under treatment and seems that this medication have to be given for certain days to accumulate in the blood up to certain levels before they start working and that is the major problem we have with anti-depressants now a days. In the past they used to take and combine anti-depressants with stimulants - stimulants usually give you an anti-depressive kind of effect right a way - a few hours probably and this was probably abandoned years ago thinking that the stimulants create a habit which is true but the anti-depressant we have in the market right now take a few days to work, they don't work right a way. The minor tranquilizers we are very concerned about them, especially this population. We have to have precautions to whom we give them because the great majority of them actually, they work very well in fighting anxiety but on the other hand, they have a great tendency to create habit, habit forming medications. The volume as a matter of fact, not using that much now a days because they are not only addictive but they have a great cumulative effect and action and they were use primarily in the 60's and it is required to increase dosages to get the same effect to the point that at times we are getting none and they will feel more depressed because some other actions the medication had. They are usually muscles relaxants, that is what many of them specially volume is used in times of fractures and treatment of fractures and other muscles injuries and that kind of things. We also have medications that were more recent that that like - transciene,

the addivan - that type of medication that are very similar to hypothenics, in other words, they are very similar to medications that are being prescribed to induce sleep, especially like the dowmain, vistrol and other medications that we try to avoid, so this is a special category that we try to avoid using this much. We have given preference to one medication in this category call vistrol that is why I under line it. Vistrol is very close related to benadryl and these are the ones that we are using the most because they don't create any habit and they probably give you almost the same relief if you go high enough into dosages. We know that these types of medications are minor tranquilizers prescribed more by the general physician than by the psychiatrist. We usually like to combine them with psychotherapy and as the progress goes along in psychotherapy, help the reduction to medication. The one involved is synax, probably that category everybody want to have synax, they use it for the day, for night to sleep and it is a great medication if you use it properly but right now New Horizon, we have sort of a non written policy among the psychiatrists that we would like to use minor tranquilizers in conjunction with psychotheraphy and the homeless population we have to use, any will give preference to vistrol that we can go as high as 100 milligrams even three or four times a day, high dosages will be around 400 milligrams and to induce sleep, we would like to use rather the hypnotic but we like to give preference to benadryl. It seems to be working O.K. patients are given 50 milligrams of benadryl to sleep and that in

combination at times with vistrol will make the trick. Now lithium, lithium is already is our system, our bodies and is a mineral oil, it is a part of our tissues so in lithium theraphy, we have to measure the blood level of lithium, it is probably one of the few medications we use which we have to take this precaution because theraputic level is very close to the toxic level. Let say that the theraputic level usually get between 0.5 and 1 at times 1.5. Once a patient goes over 2, he becomes toxic. So when we prescribe these medication we usually try not to, unless it a case that we are sure that is a bypolar case that requires the lithium. Also it does not mix very well with certain medications. Like in the major tranquilizers, you know for sure we don't like to give a combination with lithium and harbo because there has been described some cases in the literature of hypertensive crisis with a combination of the two. But we still see patients be released all the time with that combination and we immediately try to do something with the lithium or with the harbo whatever the case is and how the patient presents himself. Lithium also and this population that we in - a very hot area, we have to be careful during the summer time especially, so if for e.g. we have the patient who starts of lithium would like to lithium levels maybe once a week beginning closer to two every two weeks, then later to every month and then when they are well established, you know with the medications dosages have been determined, what is their particular specific dosage for that patient, we move it to may be three months or

every six months. But in the summer times, we like to do it more often. The reason is and the patients perspire more, there is more perspiration, there is more lithium in the body, lithium does not leave the body with persperation, stays more in the system as a matter of fact or the patient for some reason has been taking medication of the antidiarrhetic type, the water pill. They also will retain more lithium. Also we should give patients who take lithium a very good knowledge of what to expect in the form of side effects and they usually complain first of having diarrhea, or having tremors in that category we see most of them as the first symptom that appears, if they happen to be toxic or getting to toxic levels. We have used this type of medications maybe once a day or maybe twice a day, three times a day and that is another thing we are trying to do with the homeless. Homeless population, these are people who are highly mobile and times they are not there for the medication so the idea would be to give medication once per day, probably at bedtime you know - we are doing a lot of that. Also the major tranquilizer given at bedtime at times helps to sleep so we avoid using a secondary medication so we try to use the least amount of medications and when we use it, only once a day if possible. Another thing, when these people are in our system, they go to a shelter where they can stay for a few days, move to another shelter, so they follow up is very important. We would like to see them as often as possible. In certain cases we see them like every two days in other cases, we give them appointments every

week or every other week. We don't go more than 30 days but we seldom do it from the beginning for 30 days, we follow the client for a while. #6 talks about decadepo, this is a type of medication we are using now. It is an injectable form that they don't have to take orally of course, and it stays with the clients for maybe a period of two to three weeks at times even four weeks. So this seems to be the logical thing to do in many cases. There are two medications on the market right now - the hyaco and the polyxon. In that particular form hyaco being more potent. Of course, we have the problem of the side effects. If they are going to have side effects with this medication, it is going to be very hard to control and this medication is prefered to be used when the patient is in an inpatient kind of facility. At CSU, you know they go to CSU because they lack funds, or they go to Jackson and those are the ideal moments when they people should be placed in their depot type of medication. They are given usually a shot every two weeks. We have numerous people, as a matter of fact Dr. Melcher has a clinic on Tuesdays and everybody go there for a shot and they report every two weeks or most of them every month. We are trying to use that with this population but we don't have great results, you know because they move around and we don't know whether they are going to have side effects, where they are going to be when they have the side effects. Usually, the indicated thing is to give them all medication first. If you are going to use harbo for example and deca, injectable, you want to give them harbo oral first and

see what is the dosage they are going do and then make a conversion my multiplying figure and then you get the amount of milligrams they are going to need in the injectable form. We hope that in the future, not only for the homeless, but for the all types of mentally ill patients that they have longer acting medications like in the form as maybe a substantaneous pellet that would measure how much medication that particular patient needs. As Dr. was saying, when he was talking about dopamen and excessive dopamen being one of the biochemical reasons or theories that says that psychotics symptoms take place because of that excessive amount, we should say that the mechanism of action of the major tranquilizers is precisely to be a blocker - they are blockers, they block the excessive amounts of dopamen. You have to realize and we will pass some package to you that in the nervous system, there is no continuity between one cell and the other one in the central nervous system. There are gaps, spaces called cenaptic clefts and actually they pass their impulse from one to another through chemical substances. In general, they are called catacolumins but there are different types - dopamen being one of them. I always try to tell people to remember when they talk about medications for the schozophrenic patients and the side effects it can give also you have to compare that with, or you understand it better if you compare it with parkinsons diseases. You know Parkinsons disease is the opposite. Parkinsons patients have a need for dopamen so we give them eldopa, cymatrel, cojenten, you know medications that will give

that extra amount they don't have. Of course, if we give too much of those medications to Parkinson clients, we can make them schizophrenics - at least for a while. We intoxicate them, we induce the schizophrenic psychotic symptoms. So the same thing happens in the schizophrenic, we give them medications that block dopamen but if you give them too much, actually they develop a Parkinsonian type of picture and it is toxic because of excessive amount of the medication and the difficulty with all this medications especially the major tranquilizers is that we cannot say to how many milligrams of one particular medication will the patient respond well. We can say that with a minor tranquilizers more or less, figure how many milligrams a person is going need to transcene, based on their weight, we can even speculate with lithium. Lithium comes usually in 300 milligrams and we can give it from one a day to four times a day even times higher but you know we find usuaslly one particular dosage that would be the minimum dosage to control the symptoms and the anti-depressants also, we can more or less figure out by weight and we usually have at times have to go higher dosages than the general practitioner does. General practitioners treat a lot of depression but they give sub theraputic dosages which may give 25 to 50 milligrams of one medication that might require 250 or 150 to be active but in the medication of the major tranquilizers, we have the problem that we cannot really tell. So the first question we ask the patient who has a history of using major tranquilizers which one he has used and with what results. We

have to be open minded rather than forcing out medications. If the patient tell me that he did well with 60 milligrams, that is what I am going to use, they usually try to get away, they are smart enough to get away from certain medications to the point that some of them would tell you that they have side effects with all of them. But usually algo is one that gives a lot of side effects, unpleasant ones. Although I think it is probably the most active and the most potent of all of them, all the major tranquilizers. So you have to pay attention what the patient tells you and we try with the use of the medication they choose, if they choose any and try to avoid the ones they claim provide a lot of side effects. Major tranquilizers again and those names probably the habo, the navane and the perixine are the ones we use the most some doctors will continue using trilefone or others and some doctors would prescribe thorazin. The patient at times tell you that you have to prescribe certain medications like we have patients getting certain amount of thorazin, that claim that they will not function without it so you more less try for a few days and if it is true, you leave the patient the thorazin. So they very much dictate at times, the prescription we provide them. So we hope in the future we will be able to have a better type of medications that will be probably provided causing less side effects. The anti Parkinsonians said that usually have to have this precaution of not providing to many milligrams or excessive amount of pills because they are used for other purposes. Now the anti depressants, what they usually do, the

way they function is that they enhance the noropnerifine or the sonoritonin which now sonoritonin has to do a lot also with depression and it seems that depressed people have a lack of reception on the second more distant neuron of these materials. The minor tranquilizers as I said, we try to avoid as much as possible. They have a short effect for 6 hours and they have a great cumulative effect that in general they are used by us with some precaution. Anything you want to add to medication, Melcher ..... no

Questions:

Could you tell us the effects of alcohol on these?

Well, it enhances the action of most of these medications, yes, for example you are taking a major tranquilizer, you know say 10 milligrams of let us say lestizine and you are doing well and you drink alcohol, you are going to get more of the effect of lestilizine, you will be feeling over sedated, dizzy and probably not necessarily other side effects but those are probably sedation as the one we see the most.

Mr Moore:

At this time we need to give Dr. Gonzalez and Dr. Melcher a big hand of applause. These presentations have been very

informative and I Dagmar I am so glad to hear from both sides of the psychology family and I think most of us will leave here with lots of knowledge about people that we are concerned.. what I would like to do now, is to invite both Dr. Gonzalez and Dr. Melcher to join us to lunch and we will have a chance to talk to them - we are on a tight schedule now so let us move directly to the side of the room for lunch.

This conference was funded in total by a

321 Grant from the U.S. Department of Education

through the State of Florida Department of Education

Betty Castor - Commissioner

John Lawrence - Bureau Chief

Miami-Dade Community College/North Campus

Robert McCabe - President

J. Terence Kelly - Campus Vice-President

Carrie P. Meek - Special Assistant to Vice-President and Director of the Office of Public Affairs

Blanca R. Polo - Project Director

Miami-Dade Community College
DISTRICT BOARD OF TRUSTEES
Martin Fine, Chairman
Jose-Antonio Alvarado, Ofelia Tabares Fernandez,
Al Cardenas, John W. Schmitz, Louis Wolfson III, Darryl K. Sharpton
College President: Robert H. McCabe
Vice-President, North Campus: J. Terence Kelly

Miami-Dade is an equal access/equal opportunity community college and does not discriminate on the basis of handicap.